



Royal Commission
into Defence and Veteran Suicide

Military sexual violence, unacceptable behaviour and military justice

Volume 3

Final Report

Alex Seton

For Every Drop Shed in Anguish

made in Sydney, 2022–2023

Australian Pearl Marble

dimensions variable

Collection of the Australian War Memorial, acquired by commission in 2023

AWM2021.938.1

© Alex Seton

Together with veterans and their families, the Australian War Memorial commissioned this work of art to recognise and commemorate the suffering caused by war and military service. *For Every Drop Shed in Anguish* by Alex Seton provides a place in the Australian War Memorial's Sculpture Garden for visitors to grieve, to reflect on service experiences, and to remember the long-term cost of war and service.

Artist Alex Seton said, 'These rounded and abstracted liquid forms represent every drop of blood, sweat and tears ever shed by Australian military personnel and their families. It was very important that we create a different kind of memorial, not a singular heroic monument, but a grouping that acknowledges that there is a wider impact of mental and physical trauma. The large group of forms alludes to the suffering that radiates out from the individual, affecting their family, friends and communities.'

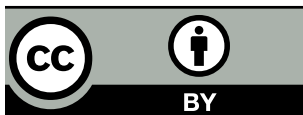
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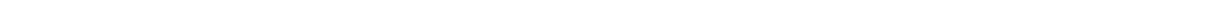


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Volume 3:

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Content warning – discussion of suicide and suicidality

This report is about suicide and suicidality among serving and ex-serving Australian Defence Force (ADF) members. It includes information related to these topics as well as experiences that have contributed to people becoming suicidal. This report includes content that readers may find distressing, confronting, emotionally-laden or otherwise difficult to read. You may find that reading this report brings up traumatic memories or strong emotional responses. We encourage you to speak with someone you trust, or you may wish to seek professional support through one of the services listed here if needed.

It is important to write about suicide, suicidality, traumatic experiences and their ramifications safely and responsibly. In the past, talking about suicide and suicidality has been taboo. We aim to approach our discussion about them in a constructive way. This report was written in line with our trauma-informed approach and using guidance from the Mindframe program.¹ We have aimed to avoid using language that might stigmatise suicide or suicidality or that might inadvertently encourage suicide. We recognise that because this report includes evidence and information provided by other people and organisations, there may be times when the language used does not always meet best practice guidelines.

Urgent support

If you require urgent or immediate help, you can:

- call triple zero (000)
- go to your local emergency department.

1 Mindframe, *A guide for media reporting on defence and veteran suicide*, 22 December 2022.

Crisis support services

Suicide Call Back Service

1300 659 467

24-hour counselling service for suicide prevention and mental health. Available via telephone, online and by video chat.

Open Arms

1800 011 046

24-hour mental health support for Navy, Army & Air Force personnel, veterans and their families.

Defence Member and Family Helpline

1800 624 608

24-hour service providing a range of practical and emotional support programs for families facing emergency or crisis.

Defence All-hours Support Line

1800 628 036

24-hour service for Australian Defence Force members and their families providing help to access military or civilian mental health services.

Lifeline Australia

13 11 14 or text 0477 13 11 14

24-hour crisis support service. Available via telephone, online and text chat.

Beyond Blue

1300 224 636

24-hour counselling service. Available via telephone, online or email.

1800RESPECT

1800 737 732

24-hour counselling service for sexual assault, family and domestic violence.

Men's Referral Service

1300 766 491

24-hour counselling, information and referral service for men concerned about their own use of violence or abusive behaviour.

MensLine

1300 78 99 78

24-hour support for men with concerns about mental health, anger management, family violence, addiction, relationship stress and wellbeing. Available via telephone, online and by video chat.

13YARN

13 92 76

24-hour national support line for First Nations people in crisis.

QLife

Call 1800 184 527 or visit qlife.org.au

The QLife phone and webchat service is available 3pm to midnight every day, providing space for where LGBTQI+ people and their loved ones can talk about anything affecting their lives.

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Part 3

Misconduct, complaints and military justice

8 Military sexual violence

Summary

Our inquiry received extensive evidence and accounts from serving and ex-serving members of the devastating impact that sexual assault and other forms of sexual misconduct have had on their and their colleagues' lives.

Sexual assault and other forms of sexual misconduct are linked to suicide and suicidality. In the Australian Defence Force (ADF), the majority of sexual violence is perpetrated by men, and the majority of victims are women. We acknowledge that men are also victims and women are also perpetrators, but these gendered patterns cannot be ignored – particularly in the context of ex-serving women dying by suicide at twice the rate of the general female population.

The ADF has implemented a range of reforms over the past decade. These include establishing the Sexual Misconduct Prevention and Response Office (SeMPRO), Sexual Offence Response Teams and a dedicated policy for reporting and responding to sexual misconduct based on a victim-centric approach.

Despite these reforms, significant problems remain.

Defence's own figures show that close to 800 sexual assaults have been reported in the ADF over the past 5 years. This is in the context of an estimated under-reporting rate of 60% for sexual assaults in Defence, and is only a subset of all forms of sexual misconduct that occur.

At the time of writing, the ADF still could not accurately quantify the prevalence of all forms of sexual misconduct in the workplace. Most managers and commanders have not undertaken dedicated training to respond to reports of sexual misconduct. There is no specific return to work policy for victims of sexual misconduct, and personnel systems are not designed to ensure victim safety.

Members convicted of sexual offences against other members remain in service. Additionally, the ADF is unable to quantify how many serving members have been convicted of sexual offences in civilian courts, even where the offences have been perpetrated at work against another member.

To say we find this concerning is an understatement. Men and women serving in the ADF have signed up knowing they may be required to make the ultimate sacrifice for their country. However, for many members, the greatest source of danger comes from within the ADF itself. Many victims do not report for fear of repercussions on their career, or the belief that there will be insufficient consequences for the perpetrator.

The ADF displays a high degree of concern that alleged perpetrators are afforded procedural fairness, and victims have choice and control over whether they report sexual misconduct. We agree that the principles of victim-centricity and natural justice are incredibly important. However, there are significant barriers to reporting sexual misconduct, which must be addressed before it can be said that victims are exercising genuine choice. Similarly, procedural fairness for an alleged perpetrator should not be used as a rationale to avoid addressing risks to the victim or the broader workforce.

In our assessment, the ADF must make significant improvements before it can confidently say it is doing all it can to protect its members from the risk of sexual misconduct at work, and the associated risks of suicide and suicidality. The recommendations in this chapter aim to improve workplace protections for victims and ensure perpetrators are held to account, while preserving a victim-centric approach and applying the principles of natural justice.

Sexual misconduct remains a systemic issue for the ADF. This has been the case for decades, and it will continue unless the ADF commits to deep, systemic reform.

8.1 Introduction

Content warning – this chapter contains first-hand accounts of sexual assault and other forms of sexual abuse.

1. Throughout this Royal Commission we have heard harrowing yet courageous testimony from serving and ex-serving members who have been sexually assaulted and harassed during their service.
2. This evidence demonstrates the devastating impact that sexual assault and other forms of sexual misconduct have had on their lives – including suicide and suicidality – and the lives of their families.
3. We would like to acknowledge all victims who have shared their experiences in public hearings, private sessions and submissions. Thank you for your courage, your strength and your resilience. We believe you.
4. In Hearing Block 1, anonymous witness BR1 told us she was sexually assaulted when she was 18 years old by a fellow Navy member. After the assault, BR1 experienced suicidal thoughts. When asked how she felt about joining the Navy, she responded:

I honestly regret it. Given that I joined at such a young age, it impacts my life now and I'm sure it is going to continue to impact my life forever.¹

5. In Hearing Block 4, another anonymous witness CB1 told us she was sexually assaulted and sexually harassed at HMAS *Cerberus*:

I didn't feel safe at recruit school. I was assaulted by my petty officer, who was in charge of my squad, and I also experienced harassment by him and other petty officers that were in charge of us, and also experienced some in relation to the other women that I joined up with. So it was a very traumatic and really awful time for me and I couldn't wait to, basically, get out of it.²

6. We have heard similar accounts in submissions, many of which were made on a confidential basis and are unable to be shared. The impact of sexual assault and other forms of sexual misconduct on serving and ex-serving members cannot be overstated – it is nothing short of horrific.
7. The following submission from a victim of multiple sexual assaults provides an insight:

I was first assaulted within the ADF several days after I enlisted. I had been enlisted into the Royal Australian Military Police and during a posting to the [redacted] Military Police Company the RSM [regimental sergeant major] indecently assaulted me when I assisted him to prepare for a function. I was very distressed. I remember vividly being alone with him and aware that he was the RSM. I had been asked to help set up for a function after a parade and I was sickened by the behaviour. He was meant to be the epitome of professionalism. I remember uncontrollably crying and I felt sickened. I did not report this assault

as I feared I would not be believed as he was the RSM and I was a Private. I felt humiliated and violated by the very person who I should have held in high esteem. I was scared to return to work because of him, I feared for my safety. I didn't know what he would attempt again.

...

It is important for me to convey to the Commission that prior to the sexual assault of [redacted], I was a loving and cherished mother and in a loving relationship with my long-term partner of 21 years. I had a healthy physical, social and psychological lifestyle and wellbeing. I now have a fractured relationship with my son and have separated from my partner. The assault has impacted every facet of my life and [has been] further perpetuated by the ADF denying the events. This event caused all other assaults to come to the forefront. I am now dealing with all assaults at once, which has taken its toll on my mental health. I had not reported previous assaults as I had to bury them and get on with it.³

8.2 Sexual misconduct in the ADF

8. In this section, we examine the link between sexual misconduct and suicide and suicidality, the gendered patterns of sexual misconduct, and reforms the ADF has implemented to date.

8.2.1 Terminology

9. The Australian Government and the ADF have not adopted the terminology of military sexual trauma/violence. Units within the ADF use different terms for victims and perpetrators of sexual misconduct.

Military sexual trauma and violence

10. Defence uses the term 'sexual misconduct' to:

encompass the spectrum of unwanted and unwelcome sexualised behaviours. Applying the term 'sexual misconduct' to describe all unwanted sexualised behaviours is common but not universal. Terms used by other agencies to cover the full range of behaviours include 'sexual harassment' and 'sexual assault'. Defence uses those terms to exclusively reflect specific behaviours as they are defined in legislation.⁴

11. We have mainly used Defence terminology throughout this chapter. However, we do not consider the umbrella term of 'sexual misconduct' adequately captures the violent nature of sexual offending or the significant physical, emotional and psychological trauma experienced by victims. In Defence, sexual misconduct includes the acts and behaviours described below:

Sex discrimination occurs when a person is treated less favourably than another person in the same or similar circumstances because of that person's sex, characteristics of that person's sex, or assumed characteristics of that person's sex ...

Sexual harassment occurs when a person makes unwelcome sexual advances, requests sexual favours, or engages in other unwelcome sexualised conduct, in circumstances reasonably anticipated to offend, humiliate, or intimidate ...

Sexual offences are acts, or intent of acts, of a sexual nature against another person, which are non-consensual. Sexual offences are defined in various Commonwealth, state, and territory legislation. Specific offences differ across the various jurisdictions but are broadly categorised as sexual assaults and non-assaultive sexual offences ...

Intimate image abuse occurs when a person takes, views, or distributes intimate images of another person without their consent. Intimate images span still or moving images of a person's genital or anal areas, and breasts for female and female-identifying people; depicting a person engaging in a private act; depicting a person in a sexual manner or context; and includes any images altered to appear to show any of these things.

Stalking offences, including actions undertaken using electronic communication methods, are categorised as a separate offence category in state and territory legislation. Stalking actions are those amounting to intimidation, harassment, or molestation, undertaken more than once, that are reasonably expected to cause apprehension or fear of harm. Stalking spans actions such as following, watching, loitering near, keeping under surveillance, sending offensive material, interfering with property, sending electronic messages to or about the stalked person, or acting covertly in another way reasonably anticipated to cause apprehension or fear.⁵

12. The Five Eyes is an intelligence alliance comprising Australia, Canada, New Zealand, the United Kingdom and the United States. Five Eyes partners including the United States and Canada, and academic experts, have recognised 'military sexual trauma' and 'military sexual violence' as specific forms of trauma and violence experienced by serving members. This terminology is yet to be adopted in Australia.

13. Military sexual trauma is 'defined as the psychological trauma resulting from experience of sexual harassment or assault in the course of military service'.⁶ The term 'military sexual trauma' is used by the United States Department of Veterans Affairs and Veterans Affairs Canada, and has been adopted by academics.⁷ We note that the UK House of Commons Defence Committee report into women in the armed forces recommended the Ministry of Defence recognise 'military sexual trauma'. The UK Government's response was that the Ministry of Defence does not use this term, but no rationale was provided.⁸

14. Professor Megan MacKenzie, Simons Chair in International Law and Human Society in the School of International Studies, Simon Fraser University, Canada provided information to this Royal Commission about her research.⁹ Professor MacKenzie uses the language of 'military sexual violence' rather than 'sexual misconduct'. She gave the following rationale:

I define military sexual violence as unwanted sexual activity perpetrated against service members by a fellow service member or members. I use this term for a couple of reasons.

One is that I argue that the term 'sexual misconduct' is problematic. It reflects a long history of ... counting sexual violence as simply one form of misconduct or unacceptable behaviour. In fact, Australia and Canada didn't even disaggregate sexual misconduct from other forms of misconduct until 2015 for Canada and 2008 for Australia.

I also think that the terms 'sexual assault' and 'sexual harassment' have their limitations because it ... perpetuates the idea that there is a hierarchy of incidents and it can perpetuate the idea that there is a threshold at which something becomes harassment or something becomes sexual violence, and I think that can be a barrier for victims reporting.

And it de-centres the victim and fails to acknowledge that all forms of sexual violence can be harmful and that so-called low-level forms of sexual violence may not in fact have a low impact for victims. So I use that term to encapsulate both what would traditionally be described as sexual harassment and sexual assault.¹⁰

15. Defence provided the following response to Professor MacKenzie:

We acknowledge Professor MacKenzie's concerns, but do not agree that Defence should adopt the term 'military sexual violence'. Replacing 'sexual misconduct' with 'military sexual violence' may act to exclude those that are impacted by 'sex discrimination' or 'sexual harassment' as these do not fall within the common understanding of the term 'violence'. In addition, Defence policy explicitly states that any individual impacted by sexual misconduct must be managed using a 'victim-centric' and 'trauma-informed' approach.

Defence adopted use of the term 'sexual misconduct' as a result of the Review into the Treatment of Women in the ADF Report 2012 (AHRC 2012). Defence is consistent in our internal and external education that this definition encompasses the spectrum of unwanted and unwelcome sexualised behaviours.¹¹

16. We agree with Professor MacKenzie that ‘sexual misconduct’ is an inadequate description of the harms caused by all forms of sexual violence. Using an overarching term such as ‘military sexual violence’ does not preclude more specific definitions about the types of behaviours this term includes. Terminology used in the ADF to discuss sexual misconduct should therefore be reviewed.

Different terms for victims and perpetrators

17. Defence uses a range of terminology when referring to individuals involved in unacceptable behaviour, which also applies to sexual misconduct incidents. These terms are set out in Table 8.1.

Table 8.1 Defence terminology used in sexual misconduct

Unit / Area of expertise	Terminology	
Complaints and Resolutions	Complainant	Respondent
Defence Response Unit	Survivor	Alleged Perpetrator
Joint Military Police Unit	Victim	Named Person (if the victim does not wish to proceed with formal action) Person of Interest (if the victim wishes to formalise the allegation, but evidence is yet to be collected) Suspect (formalised allegation with evidence to now identify the Person of Interest)
Sexual Misconduct Prevention and Response Office	Impacted Person	Alleged Perpetrator

Source: IDI Exhibit 01-03.104, Department of Defence, Complaints and Resolutions Manual, Chapter 9 – Responding to sexual misconduct, DEF.1096.0001.1136 at 1152 [A.1].

18. Throughout this chapter we have used the terms ‘victim’ and ‘perpetrator’, which we consider to be appropriate in the context of sexual assault, sexual harassment and other forms of sexual abuse. We note the qualifier of ‘alleged’ is always used in Defence terminology when referring to perpetrators. This chapter only uses that qualifier when necessary (such as before a finding of guilt or the substantiation of an incident).

8.2.2 Sexual misconduct is directly linked to suicide and suicidality

19. We heard a range of evidence from academics, Defence leaders and previous heads of inquiries connecting experiences of sexual misconduct with suicide and suicidality.¹² Group Captain Fleur James, Head of the Sexual Misconduct Prevention and Response Office (SeMPRO), acknowledged that sexual misconduct can have a negative impact on victims’ health and wellbeing, which can extend to suicidality and, in some cases, suicide.¹³

20. Commissioner Brown asked then Vice Chief of Defence Force (VCDF) Admiral David Johnston AC RAN in Hearing Block 12 what might contribute to higher rates of suicide for ex-serving women compared to the general female population. He responded:

we have, given those circumstances, deep thought, particularly in those communities where it is clear there is a higher risk after their separation from permanent service, I think ... in the case of ADF women, the statistics are quite clear to us that they are more subject to unacceptable behaviour, sexual misconduct than men are in service and that, you know, would be, amongst others, a significant contributing factor to the risks that they carry as they transition into their postmilitary career.¹⁴

Lived experience evidence demonstrates the link

21. As discussed in section 8.2.3, women in the ADF experience sexual assault and other forms of sexual misconduct at significantly higher rates than men. As a result, the majority of experiences we have heard about relate to women.
22. Ms Alexandra Shehadie told us what she had learnt from her work on the 2012 *Review into the Treatment of Women in the Australian Defence Force*:

The impact of sexual misconduct, so, sexual harassment or sexual assault, what we have learnt over the years in our work is it can be devastating and it can be short, medium and long term, those impacts. What the women in the ADF told us, who had been harassed or sexually assaulted, is that they experienced anxiety, depression, a sense of fear, a loss of self-esteem and confidence, relationship dysfunction or breakdown. We did hear from some that they had experienced suicidal ideation or were actually suicidal.¹⁵

23. Reverend Dr Nikki Coleman is a Uniting Church minister who joined the Air Force as a chaplain in 2017. Reverend Dr Coleman told us about the impact of sexual misconduct, including indecent assault without consent, on her physical and mental health:

I am very resilient. I've worked in a male-dominated area as a minister for years and this abuse had an impact on me unlike any other workplace I've ever had before. Partly the abuse, but also I was begging for help and asking for it to stop from my senior leaders and it just wasn't happening. One person did intervene and it actually got worse. I was in a difficult situation. My husband was very sick and so I was really sustaining us financially and looking after us, and so I didn't have any alternative to go elsewhere. The abuse itself has had a profound impact on my mental health and my physical health, and I've been really resilient throughout all my life and I think everybody has their breaking point and, unfortunately, I found mine.¹⁶

24. Submissions also demonstrated the link between sexual misconduct and suicide and suicidality. Of the 492 submissions we received that discussed sexual misconduct, 36% also discussed suicidal thoughts.

25. For instance, one person who made a submission told us about:

Many years of abuse, and more recently the sexual abuse by spouse who is a serving ADF member upon myself. Have been reporting the abuse over the last several weeks. Informed the workplace Orderly [R]oom, 2 [p]adres, DMFS [Defence Member and Family Support], S[e]MPRO and Military Police as advised by DMFS ... I have since the end of July had now 4 hospital admissions due to suicidal ideation with the thoughts of following through with these thoughts to end my life due to lack of support from Defence offered services and the lack being proactive on Defence's end to these allegations.¹⁷

26. In another submission, a veterans' compensation advocate told us:

One of my clients, aged 35, [died by suicide]. He was a victim of sexual abuse as an adult serviceman, developing chronic psychiatric illness as a result. He was medically discharged on psychiatric grounds. He lost the career, friendship circle and identity that came with permanent Defence Force employment.¹⁸

27. We also heard from a cadet about their experience, which occurred within the past 5 years:

I started my training at [redacted], it felt like a normal army training, exactly what I expected. A few weeks into the training, when we were at the shooting range learning different positions, a sergeant (person of authority for us cadets) was inappropriately behaving and touched me in a sexual manner from behind when supervising me on how to hold the rifle properly while standing. Other cadets saw this too. Fast forward a few weeks it came to light that the same sergeant has done similar things with other cadets too. We complained about the sergeant by filling out white papers. Action was taken by the commanding officer of [redacted] and the military police, however the conduct of the investigation very open. For example, when the CO [commanding officer] and some other staff members came to talk to us for the first time after the incident, our names were mentioned at the end of a lecture, everyone knew something was wrong. This could've been done in a discrete manner. When military police came for the interviews, everyone knew we are being interviewed as we had to sit and wait outside the headquarters. The whole student cohort knew about what was going on and it was very embarrassing. On top of everything, I developed pain in my back. I had to beg to be seen by the medic in most instances as some staff members did not take it seriously when I complained of the pain. I felt like I failed myself by joining the army, I did not expect harassment or disrespect from an elite training school. It took a massive toll on my mental health that I considered committing suicide. My plan was to [redacted], however I changed my mind in the last minute due to protective factors.¹⁹

28. We also heard from victims of recent and historic gang rape who had experienced suicidality and lifelong impacts:

In early 1997, I was 18 and a young army reservist. I was gang raped by a group of young officers. I have struggled with this all my adult life. It has effected every aspect of my life. It has shamed me. I wanted to die for much of my 20s. I tried to kill myself.

I fear telling anyone. My own husband of 15 years is not aware.

I'm 45 now. It will never leave me.²⁰

29. Another victim told us:

I also experienced attempted suicide 2018 after being sexually assaulted. By two men I worked with. I received very little to no support. Was told to just move on. My OC [officer commanding] was very insistent that it was all just a misunderstanding. And put me in an ATODs [alcohol, tobacco and other drugs] program because I'd had too much to drink. In Dec 2017, I was fresh to the army just posted to [redacted], I was very excited about starting my new career. I was made to attend a mandatory Christmas work function. Yes I'd had a lot to drink but nothing could prepare me for what was going to happen but also the months and years to follow.

I was taken back to my room on base by these two men I had only known for a week ... the next thing I remember is my best friend walking in as they had left the door unlocked. She asked me if I wanted this. He answered yes for me. [Redacted] asked me again and I shook my head saying no ...

My OC put me on leave and sent me back home to my mother in [redacted]. I still hadn't met the OC. He had given me a support officer which I soon found out later that he was the second offender's LT. After being moved to [redacted] at my request after lots of pushing, I became very isolated and depressed. I was seeing a psychologist on base but did not find that helpful ... In 2019, I decided to chase it up with ADFIS once again, getting no support. And was told that there was reasonable doubt. So with that and feeling trapped I made the decision to medical discharge from the ADF.²¹

30. We also heard from victims who had been sexually assaulted and subsequently harassed, resulting in suicidality and significant mental health issues:

I was a victim of sexual abuse the day prior to overseas deployment to East Timor. The assailant was a senior member of my unit, [redacted], who was drunk at the time of the assault. Whilst on deployment I was subjected to humiliating behaviour by him as my superior, I was ordered to do mundane tasks and was monitored daily. His behaviour was of intimidation, harassment and humiliation. This resulted in me sitting in my room alone on New years eve 1999 / 2000 [description of suicidal ideation]. I don't recall why I didn't take my own life that night.

On return to Australia the behaviour continued until I went on leave. When I was due to return to work, I had a complete mental health breakdown and was hospitalised due to major depression. I made a formal complaint to my Commanding Officer and a formal investigation was commenced and many witness statements were taken by the Military Police. The guilt of the [redacted] was never in doubt, however when it came to handing out punishment instead of being placed before a Courts Marshall, he was issued a Formal Warning and was allowed to remain in the Unit and the Army. I however was an outcast and made to feel that it was my own fault and that I was lying about the incident. I was removed from my unit and sent to work at the local dental unit. I was given an opportunity to Corps Transfer which I accepted. However, soon the weight of [being] ridiculed bore its weight upon me and I attempted to take my own life [redacted].²²

31. We also heard from a member who did not receive appropriate support when they reported sexual assault or suicidality:

The lack of compassion and appropriate response to raising complaints of sexual abuse in 2015/2016 and victimising victims by issuing termination notices following going to NSW police about sexual assault, I became severely depressed and suicidal but was not taken seriously and was told if I would kill myself I'd be doing the ADF a favour by my direct supervisor, a warrant officer.²³

32. The link between the trauma of sexual misconduct and suicide and suicidality was also highlighted by Ms Chrystina Stanford, Canberra Rape Crisis Centre CEO:

There is a clear link between the untreated trauma of sexual violence and suicide. CRCC [Canberra Rape Crisis Centre] responds to more risk of suicide amongst the client population than any other impact of trauma. The link is in the impact of isolation, and the lack of safety for those impacted to seek help, and the lack of places for survivors to go to seek help.²⁴

International research confirms suicidality link

33. Research confirms links between 'military sexual trauma' and suicide and suicidality.²⁵
A literature review by Phoenix Australia concluded:

No Australian studies were identified, however three U.S. studies and one U.K. study provide evidence of a relationship between military sexual trauma and mental health outcomes including suicidality. Taken together the studies provide preliminary evidence that military sexual trauma may be associated with masculinity challenges among male veterans, and this may have impacts on mental health including suicidality. For women veterans, military sexual trauma appears to have a more direct association with mental health outcomes including suicidality.²⁶

34. Phoenix Australia provided the following summary of studies in the UK and US:

Three U.S. studies, including both qualitative and quantitative methodologies, examined the relationship between military sexual trauma and mental health outcomes including suicidality. Monteith et al. (2019) examined men's perceptions of the impact of military sexual trauma in relation to suicide ideation and attempts. Using qualitative interviews, they found that men who had experienced military sexual trauma reported impacts relating to masculinity and self-blame that in turn were related to suicidal thoughts and behaviours.

In a quantitative investigation, Juan et al. (2017) also found aspects of masculinity mediated the relationship between military sexual trauma and mental health outcomes. Specifically, for men, military sexual trauma was associated with masculine gender role stress relating to emotionality which in turn was associated with depression symptoms.

One U.S. study examined military sexual trauma in women veterans, and found that those who had PTSD [post-traumatic stress disorder] from military sexual trauma were two to three times more likely to report suicide ideation, compared to women with PTSD relating to other traumas including deployment/combat (Blais & Monteith, 2019).

Hendrikx et al. (2021) found that for U.K. women veterans, experiences of military sexual trauma and bullying within the military were associated with poorer mental health outcomes including PTSD, physical somatisation, alcohol difficulties and mental health difficulties. Suicide ideation was not specifically examined.²⁷

35. A 2016 US study reviewed the healthcare records of over 6 million US ex-serving members. It found veterans who had suffered military sexual trauma were significantly more likely to die by suicide compared with ex-serving members who had not experienced such trauma.²⁸ Similarly, other US studies have shown that ex-serving members who experienced military sexual trauma were at a higher risk of attempting suicide.²⁹

36. Some studies have attempted to quantify the extent to which the experience of military sexual trauma increases the risk of suicide or suicidality. Professor MacKenzie referred to US Department of Veterans' Affairs research from 2016 that found:
- Ex-serving men who experienced military sexual trauma are 70% more likely to die by suicide compared with other former serving men.
 - Ex-serving women who experienced military sexual trauma were twice as likely to die by suicide than other former serving women.³⁰
37. In addition to the impact of the sexual trauma itself, the research demonstrates the impact of 'institutional betrayal'. For example, a 2016 study analysed feelings of being unsupported by the military. It found that victims of military sexual trauma who felt the military had 'betrayed' them – including by its failure to effectively prevent or respond to the wrongdoing – were associated with a range of mental health conditions and an increased risk of attempting suicide.³¹
38. The impact of institutional betrayal was also highlighted by Ms Stanford from the Canberra Rape Crisis Centre:

Most survivors of sexual violence disclose sexual violence because they 'do not want what happened to them to happen to anyone else'. A need based within integrity. When this fails, the consequences for the victim/survivor are catastrophic and where the person is connected to an institution, where they may be reliant on the institution for an education and future (such as universities), there is also a higher risk of loss of faith and hope in the institution. This is a significant issue where the institution is the defence force and risks leaving people ill-equipped to manage what is occurring for them and isolated from seeking help. Suicide becomes the solution to overwhelming impact.

Many people join police, ambulance, defence force or other first responder services because they 'want to make a difference' to the community or the country. Statistically speaking there is a high chance of many of these people already being survivors of some type of earlier trauma. If there is a sexual assault and the institution responds poorly, there is a loss of faith in the ideal, a loss of hope in the institution as well as trauma impacts. This creates a complex set of issues requiring careful navigation to assist the person to recover.³²

Australian research is lacking

39. Phoenix Australia's literature review found there were no Australian studies regarding military sexual trauma and suicide and suicidality.³³ We commissioned qualitative research from Professor Ben Wadham, Director of Open Door: Veteran Integration Transition Wellbeing at Flinders University, based on life course interviews with ADF members and family members of ex-serving members who died by suicide. It found that:

Women and men experienced military sexual assault but in different contexts and ways. Men were principally assaulted in unit hazing or initiation incidents by other men, while women were principally assaulted by male peers or commanders.

Rape and sexual assault placed the service member at risk of self-harm and suicidality.³⁴

40. Quantitative research by La Trobe University examined the factors that influence ADF members' ability to adjust to civilian life after service.³⁵ The research was based on a survey of 198 ex-serving members who discharged on or after 1 January 2004.³⁶
41. La Trobe found that 'increased exposure to ... military sexual trauma' related to 'greater adjustment difficulty'. Adjustment 'was not significantly different between women and men' who reported exposure to military sexual trauma. However, the study noted 'the small number of female (n=33, 16.7%) and transgender (n=1, 0.5%) participants may have limited identification of gender-related differences in adjustment'.³⁷
42. The research found that:

Almost one in five participants had experienced military sexual trauma, which also predicted a more difficult adjustment. This appears to be the first data reporting prevalence of military sexual trauma among Australian former service members but is consistent with international research, which has suggested 17.5% of military personnel and veterans reported experiencing military sexual trauma (Wilson, 2018).

The detrimental impact of military sexual trauma on adjustment is supported by previous research into the adjustment experiences of former service members (Burkhart & Hogan, 2015; Katz et al., 2007, 2010). Evidence suggests that military sexual trauma negatively influences physical and mental health and recovery can be more difficult than recovery from civilian sexual trauma due to repeated exposure, barriers to accessing formal and informal support, and conflict between feelings of 'victimization' with military values and ideals (Averill et al., 2018; Bell et al., 2018).³⁸

43. The research also noted that 'exposure to military sexual trauma has been linked to increased prevalence of a range of physical and mental health disorders, and adjustment difficulties'.³⁹ The research did not explore the link between military sexual trauma and suicide directly, but noted the connection between a difficult adjustment (such as transition to civilian life) and suicide.⁴⁰ See Chapter 23, Transition from military to civilian life, for further discussion on the risks of suicide during transition from military to civilian life.
44. In 2018, Defence commissioned a study on male victims of sexual assault in the ADF. It found:

Sexual violence perpetrated against men is likely to be underreported. While women are disproportionately affected by sexual violence, the number of men in the ADF and the reported prevalence across different militaries demonstrate that a significant number of men in the ADF will have experiences of sexual violence.

...

Many of the participants' immediate reactions to sexual violence, such as shock and anxiety, were consistent with literature on sexual violence and trauma. The ongoing impacts of sexual violence for participants were ongoing and extensive.

Men described impacts on their mental health, physical health, relationships, identity and careers ... Immediate reactions of feeling frozen and wanting to isolate or hide after the assault were reported. Shock at the betrayal of trust was a prominent theme for how participants described their initial reactions. For many participants this sense of betrayal extended beyond the perpetrator, to the ADF more generally and was accompanied with anger.

...

Suicidality and self-harm were evident in participants' reactions to the assault. All participants provided examples of the negative psychological impact of sexual violence.⁴¹

45. It is concerning that these studies represent the only quantitative and qualitative research we have identified on the prevalence and impact of military sexual trauma among ex-serving ADF members. An expanded evidence base on the extent serving and ex-serving members have been subject to military sexual trauma in the ADF is needed to understand the scale of the issue, and ensure appropriate supports are in place during and after service. This should include the links with suicide and suicidality, other impacts experienced during service, and specific needs at the time of transition. This research should also examine the terminology of 'sexual misconduct' used by Defence. We agree with expert witnesses that the term 'sexual misconduct' is insufficient to capture the violent nature of acts it is meant to describe. It also fails to convey the physical and psychological trauma these acts cause.
46. See Chapter 29, Use of data and research by Defence and DVA, on recommendations aimed at improving data quality and access to better enable this type of research, which should be made publicly available.

Recommendation 14: Understand the prevalence and effects of military sexual trauma and improve responses to support victims

The Australian Government should commission independent research on the prevalence of military sexual trauma among serving and ex-serving Australian Defence Force (ADF) members. This research should examine:

- (a) the link between sexual misconduct and suicide and suicidality, other impacts experienced during service, and specific needs of victims at the time of transition, and benchmark the ADF response with best practice approaches to inform recommendations for improvements
- (b) the terminology 'sexual misconduct' used by the ADF, compared to 'military sexual trauma and violence', and the impact of terminology on victims.

8.2.3 There are clear gendered patterns of sexual misconduct – male violence against women

47. We acknowledge that men in the ADF experience sexual misconduct, including sexual offences. The impact of sexual misconduct on male victims is significant, including suicide and suicidality. However, historical and current data clearly show women experience sexual misconduct at higher rates than men.

Women experience sexual misconduct at significantly higher rates than men

48. The Defence Abuse Response Taskforce (DART) noted that ‘almost all’ incidents of sexual abuse between 2000 and 2011 it examined were experienced by women.⁴² The Hon Leonard Roberts-Smith RFD KC, Chair of DART from November 2012 to November 2014, told us ‘it appeared to be the case that sexual abuse which had occurred in Defence in recent decades had been experienced almost entirely by women’.⁴³ This trend has not changed.
49. Then Chief of the Defence Force General Angus Campbell AO DSC acknowledged ‘women continue to experience unacceptable behaviour at higher rates than their male counterparts and women are twice as likely to experience sexually related unacceptable behaviour’.⁴⁴ Data from the Workplace Behaviours Survey (Figure 8.1) suggests women are around four times more likely to experience sexual misconduct.
50. The ADF has also publicly reported that ‘women have consistently experienced a less safe work environment than men’ over the past decade.⁴⁵ The Head of SeMPRO, Group Captain James, agreed with this assessment and confirmed that sexual harassment, sexual discrimination and sexual abuse continue to be an issue for women in the ADF.⁴⁶
51. Ex-serving ADF member and Director of Veterans Retreat Ms Kylie James described the threats experienced by women from their fellow servicemen:

a lot of people that have PTSD have it from life-threatening things that have happened to them in training command, such as assaults, sexual assaults, rapes and other things. I mean, you know, it astounds a lot of the male veterans when I tell them when I deployed to Iraq I was issued a rape whistle. Their minds are blown because they weren't. Why weren't they issued a whistle? We were given a separate brief and that was one of our biggest threats, was being raped on base. So there is more than just being shot at and being bombed, that's for sure.

... Sadly, at least 90 per cent of female veterans that attend our retreat have had some sort of sexual assault, bullying or harassment, some horror stories that I can't even believe myself, and we have had women from the old RAC [Royal Artillery Corps], so women in their 70s, that were around in the Vietnam days attend all the way down to 20-year-olds that are currently serving.⁴⁷

52. Submissions also highlighted the experiences of women as victims of sexual misconduct:

Before I joined the Army, my friends and family warned me about the sexual assaults in the Army. I responded at the time 'no way, that was all years ago, it will be fine now'. I was so wrong. I can't in good consciousness recommend the Army as a place to work for any female, which truly saddens me as someone who has many grandparents and great grandparents that were Veterans and that I want to honour.⁴⁸

53. Chapter 7, Culture and leadership, and Chapter 9, Unacceptable behaviour and complaints management, examine women's experiences of ADF culture and unacceptable behaviour more broadly. The following section focuses specifically on women's experiences of sexual assault and other forms of sexual misconduct.

54. The *Women in the ADF Report 2021–22: Ten Years in Review* found the ADF has a 'culture still marked by gendered sexual misconduct':

There are significant differences between ADF women and men's experiences of sexual assault. Women disproportionately experience and report sexual misconduct.⁴⁹

55. SeMPRO client data reflects a similar picture. Of:

the SeMPRO clients who have been directly impacted by sexual misconduct between 2013 and 30 June 2022, just over 77 per cent are women, almost 22 per cent are men, and [1] per cent identified as non-binary or did not provide a gender.⁵⁰

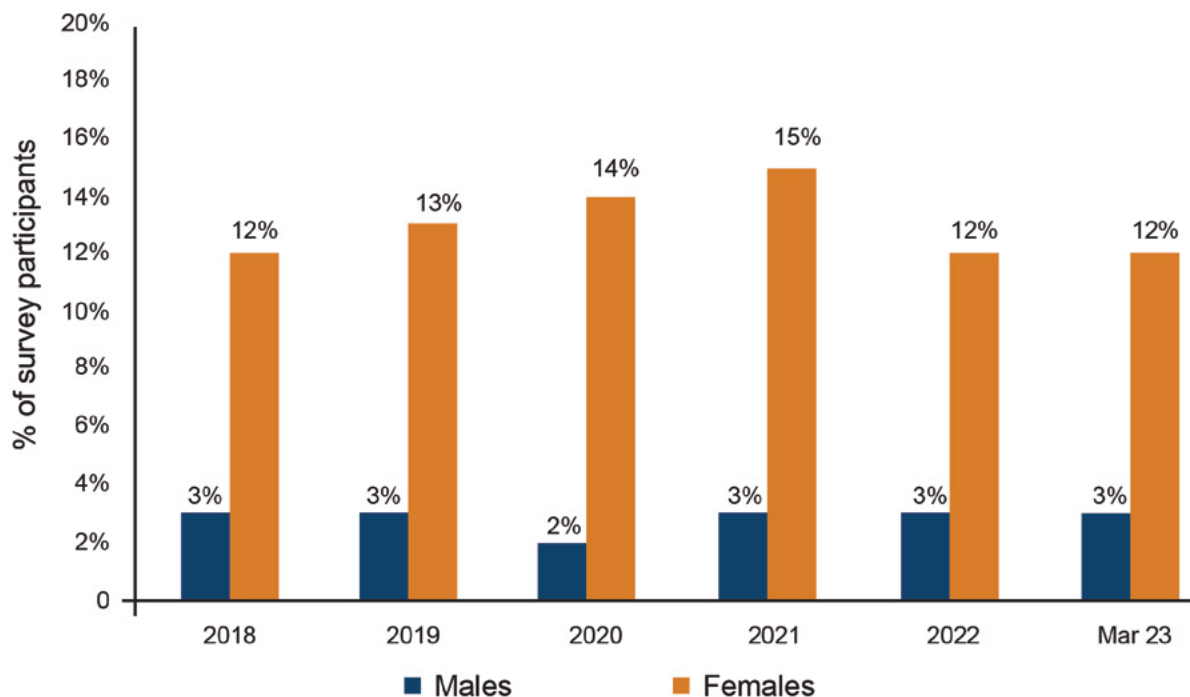
56. In 2021–2022, 90 per cent of SeMPRO's support clients were women.⁵¹

57. SeMPRO's 2021–22 annual report stated 'the majority of incidents disclosed by Support clients [victims] in 2021–22 were sexual assaults rather than other types of sexual misconduct'. This 'continues a long-term trend in the type of incidents experienced by Support clients'. It shows SeMPRO is used 'primarily by people who had experiences at the criminal end of the sexual misconduct spectrum'.⁵² In 2021–22, 60% of SeMPRO support clients disclosed sexual assaults (defined as a 'penetrative sex offence').⁵³

58. SeMPRO does not ask victims to disclose when an incident occurred. Of those who did, most revealed the sexual assaults and other forms of sexual misconduct had occurred within the previous 12 months.⁵⁴ This is clearly not an historical issue. Over half of the victims who contacted SeMPRO for support in 2021–22 were serving ADF members (13% Navy, 23% Army and 16% Air Force), 6% were ex-serving, 8% were civilians, and the service status was unknown for 34%.⁵⁵

59. This gendered pattern of sexual misconduct is also demonstrated by analysis this Royal Commission conducted using data from the Workplace Behaviours Survey. Figure 8.1 shows the proportion of ADF survey participants who had experienced sexual misconduct in the previous 12 months, with female survey participants around four times more likely to have experienced sexual misconduct than male participants each year between 2018 and March 2023.

Figure 8.1 Proportion of permanent ADF survey participants who experienced sexual misconduct in the previous 12 months



Note: Analysis includes permanent ADF members and does not include trainees or reservists. Please see Appendix L Defence survey data, for further information on the survey data analysis and interpretation.

Sexual misconduct is almost always perpetrated by men

60. SeMPRO annual reports and Women in the ADF reports only provide a gender breakdown for victims of sexual misconduct. They do not provide a gender breakdown for the perpetrators of assaults, even when this information is known.
61. We asked Defence to provide the gender of victims and alleged perpetrators of sexual misconduct from 1 January 2018 to 1 October 2023. This data confirmed the majority of victims (over 80%) are female, and the majority of alleged perpetrators (over 90%) are male.⁵⁶
62. SeMPRO's 2021–22 annual report notes 'male and female Support clients used SeMPRO services differently', with men delaying initial contact for longer than women after an incident. SeMPRO highlights that 'some people, such as men' have additional barriers to seeking help after experiencing sexual misconduct. It notes that, in general, 'men are less likely than women to seek help from health professionals' and that this 'is exacerbated when the nature of the experience runs counter to traditional masculine ideologies'.⁵⁷

63. Barriers to help-seeking from men (for support following sexual misconduct as well as broader physical and mental health issues) have been demonstrated throughout this Royal Commission. However, it is concerning that SeMPRO does not also highlight the significant barriers faced by women reporting sexual misconduct in a military environment, nor that men are almost always the perpetrators of sexual misconduct against both men and women. Future SeMPRO and Women in the ADF reports would benefit from a more balanced and rigorous analysis of gender dynamics in the context of sexual misconduct offending and reporting.

8.2.4 Inquiries and reforms since 2012

64. There have been two significant inquiries into sexual misconduct in the ADF in the past 15 years. First, in 2011, then Minister for Defence the Hon Stephen Smith MP requested the Australian Human Rights Commission inquire into the treatment of women in the Australian Defence Force Academy, and then into their treatment in the ADF more broadly. Second, in 2021, the Inspector-General of the Australian Defence Force (IGADF) initiated an inquiry into military justice arrangements for dealing with sexual misconduct in the ADF. We examine what these inquiries found and recommended, and the progress made in implementing their recommendations.

Review of the Treatment of Women in the ADF, 2012

65. Ms Elizabeth Broderick conducted the 2012 Review into the Treatment of Women in the ADF (also known as the Broderick Review), in her role as Sex Discrimination Commissioner. This review (which is also discussed in Chapter 7, Culture and leadership) encompassed a broad range of areas relevant to women. It identified a range of systemic issues relating to sexual misconduct:
- Some ADF workplaces are highly sexualised environments, which ‘could be particularly degrading to women’.
 - Some members believed that making a complaint would have a detrimental effect on their careers, and ‘some women said they simply felt they would not be believed’.
 - While there were some strong sexual misconduct policies, implementation could be ‘ad hoc and deficient’.
 - There was inadequate collection and ‘strategic use’ of sexual misconduct data.
 - Prevention and education measures ‘do not go far enough’, and in many cases are not ‘appropriate or effective’.⁵⁸
66. The review’s recommendations specific to sexual misconduct included:
- The Chiefs of Services Committee should strongly and unambiguously commit to ensuring ‘every sexual offender and harasser will be held to account together with leaders who fail to appropriately address the behaviour’.

- Women in the ADF annual reports should include the number and type of internal and external sexual misconduct complaints, relevant demographics of victims and perpetrators, and the time taken to resolve investigations.
- Establish SeMPRO 'to coordinate timely responses, victim support, education, policy, practice and reporting for any misconduct of a sexual nature, including sexual harassment and sexual abuse in the ADF'.
- Urgently investigate mechanisms to allow members to make confidential (restricted) sexual misconduct reports to SeMPRO.
- Urgently review all relevant policy and legislative provisions to provide for the mandatory assessment of an ADF member's ability to perform the inherent requirements of their job if convicted of any criminal offence, in particular any sexual offence.
- Amend all policies to ensure the waiver of Initial Minimum Provision of Service and Return of Service Obligations for victims of sexual misconduct.⁵⁹

67. SeMPRO was consequently established in 2013, with two primary roles:

Education. SeMPRO is Defence's subject matter expert in designing and delivering sexual misconduct education. Its suite of education products include Defence's mandatory sexual misconduct awareness training, incident management and response workshops, podcasts, and ad hoc information presentations.

Client Response. SeMPRO provides a 1800 SeMPRO (1800 736 776) service staffed by health professionals, who deliver 24/7 advice and support on unwanted sexualised behaviours in Defence.⁶⁰

68. SeMPRO provides support to three different client groups:

- Victims (known as 'support clients') seeking health and wellbeing support can access 'a range of services matched to their specific needs', and make confidential (unrestricted) reports.
- Commanders, managers and other personnel, as well as family and friends (known as 'advice clients'), can seek advice on managing or responding to a disclosure or report.
- Debriefing clients who are 'indirectly exposed to trauma' can receive mental health support.⁶¹

69. SeMPRO has developed a dedicated sexual misconduct policy as part of the Complaints and Resolutions Manual, and victims of sexual misconduct can have service obligations waived.⁶² However, a range of systemic issues the Broderick Review identified still exist today. Members convicted of sexual offences are still serving, and public reporting on sexual misconduct complaints is limited. There are still cultural and organisational barriers to reporting sexual misconduct, and prevention efforts are limited. Many of these issues were identified by an IGADF inquiry undertaken almost a decade after the Broderick Review.

IGADF Own-Initiative Inquiry, 2021

70. In 2021, IGADF engaged Professor Pru Goward to conduct the Own-Initiative Inquiry: Implementation of Military Justice Arrangements for Dealing with Sexual Misconduct in the Australian Defence Force (IGADF Inquiry). It initiated the inquiry as 10 years had passed since the suite of cultural reviews undertaken in 2011 following the 'ADFA Skype Incident', in which a male cadet secretly filmed himself having sex with a female cadet and shared it via Skype.⁶³ The IGADF directed the inquiry to:
- report on the implementation of sexual misconduct policy applicable to the ADF
 - if necessary, make recommendations for how implementation of relevant military justice arrangements could be improved.⁶⁴
71. The IGADF Inquiry made 13 recommendations to improve the management of sexual misconduct in the ADF.⁶⁵ Recommendations related to data and reporting, preventing and responding to sexual misconduct, and measuring the effectiveness of sexual misconduct policy. Annexure 8.1 provides a detailed analysis of Defence's response to each recommendation, all of which were accepted in full or in an amended form, and the extent to which it has implemented each recommendation to date.
72. This analysis demonstrates that as at May 2024, two and a half years after the IGADF Inquiry delivered its report, *Own-Initiative Inquiry: Implementation of Military Justice Arrangements for Dealing with Sexual Misconduct* (IGADF Inquiry report), Defence and the ADF have not implemented the recommendations in full. In particular:
- Defence has not
 - identified the objectives of its sexual misconduct policy
 - assigned suitable targets to be achieved within given timeframes
 - identified suitable metrics to measure the impact of its sexual misconduct policy
 - adopted a greater focus on developing targeted prevention and behaviour change programs.
 - Victims of sexual misconduct are not provided written advice about the possible outcomes that may be available if a complaint is reported.
 - The ADF does not report, in a deidentified manner, the disciplinary and administrative sanctions outcomes of substantiated sexual misconduct complaints, and this information is not included in annual mandatory training.
 - Defence still does not have a reliable integrated dataset for sexual misconduct, and cannot effectively understand the extent of sexual misconduct nor measure the effectiveness of prevention and response efforts.

Insufficient progress has been made

73. The importance of addressing sexual misconduct in the ADF cannot be overstated. Ms Alexandra Shehadie gave the following summary on the impacts of sexual misconduct that were uncovered by the Broderick Review:

They [female victims of sexual misconduct] often left the ADF, they were moved from their base or they took time off, often for an extended period of time ... What we found was that sexual abuse of women ruins lives, divides teams and undermines capability.⁶⁶

74. Ms Shehadie's comments make it clear that sexual misconduct impacts both individuals and the broader workforce, and negatively impacts military capability. The IGADF Inquiry report also noted the direct links between reducing sexual misconduct and maintaining Defence's values, which underpin 'member welfare, safety and Defence capability'. This was echoed by commanding officers, who believed that 'effective team work required working environments of mutual respect and that the management of sexual misconduct would contribute to greater capability'.⁶⁷
75. Defence has taken actions in relation to sexual misconduct since the Broderick Review, but they have failed to deliver deep systemic change. Group Captain James, Head of SeMPRO, accepted that:
- Women have consistently experienced a less safe work environment than men over the past decade.⁶⁸
 - Women disproportionately experience and report sexual misconduct.⁶⁹
 - Sexual harassment is more prevalent in Defence than some other workplaces.⁷⁰
 - Defence does not have an accurate picture of the extent and nature of sexual misconduct. As a result, Defence does not have data to support targeted initiatives relevant to sexual misconduct, or measure the effectiveness of policies aimed at responding to and preventing sexual misconduct.⁷¹
 - Systemic constraints may jeopardise victims' safety, including some that have been highlighted since the 2012 Broderick review, and which Defence is still working to solve.⁷²
 - Nothing had been done to create a policy to support victims of sexual misconduct to return to work.⁷³
 - Twelve years after the Broderick review, Defence still has no mechanism in place to identify or address prevalence, trends or key issues in relation to sexual misconduct.⁷⁴
76. These issues are further discussed throughout this chapter.

8.3 Data, reporting and prevalence

77. Our inquiry examined problems with reporting sexual misconduct in the ADF, from barriers to making a report, to the data the ADF holds and publishes on the outcomes of reported incidents.

8.3.1 Reporting sexual misconduct

78. Victims of sexual misconduct can report the incident to:
- the Joint Military Police Unit (JMPU) for prosecution of sexual offences under the *Defence Force Discipline Act 1982* (Cth), or referral to civilian police
 - their chain of command for administrative action (for sexual harassment and sexual discrimination), and potential referral to JMPU or civilian police (for sexual offences), noting both criminal/disciplinary and administrative action can occur in relation to sexual offences
 - civilian police or the Australian Federal Police, for prosecution of sexual offences under the relevant state or territory legislation
 - an authorised officer under the *Public Interest Disclosure Act 2013* (Cth).⁷⁵
79. All sexual offences are notifiable incidents, but sexual harassment and sex discrimination are not.⁷⁶ Victims can also make a 'restricted disclosure' to SeMPRO, which enables them to access support services without triggering notifiable reporting obligations.⁷⁷
80. Regardless of the reporting avenue, Defence policy makes it clear that the victim's wishes must be respected at all times, and it is their decision whether a report should be investigated and progressed.⁷⁸

There is wide-scale under-reporting of sexual misconduct

81. Under-reporting has been a known issue for many years. A victim of multiple sexual assaults described the barriers to reporting:

I was raped by four serving members of the ADF. I had been enlisted in the ARA for less than a year. All four of these members [outranked] me. This imbalance of power and my lack of faith in my CoC [chain of command] all lead to an inability to report. I have blamed myself and struggled for 20 years to call it rape as I was made to believe that I was to blame.

What I can see 20 years later, with help from my treating psychologist, is that I was a victim of a calculated, targeted scheme. Horrific, traumatic and isolating. Now I realise the sophistication and procedural tactics used, not only that night, but in the lead up to that night.

Having only been in the ARA for a short time, being threatened by the offenders (one of whom lived within the same complex as me on base), and having little faith in my CoC, I did not report the incident.

I felt scared and trapped and I thought reporting it would have catastrophic repercussion[s] for me and my career. I did not want to lose a career I had wanted and worked so hard for.

This was not the Army I envisaged.⁷⁹

82. We also heard from a victim of sexual assault who made a formal report but ‘felt blamed’:

[redacted] sent me an email apologising for what happened, and I reported the incident to the Military Police. The first thing they asked me, was why did I not lock my door, so I felt blamed straight away. I told them that I had but they came out and checked anyway, only to find the lock was faulty. The investigation took almost 12 months and after all that time I received a phone call from the MPs acknowledging that an assault had taken place, but stating no military law was broken because [redacted] wasn’t on base at the time – they suggested that I go to the police.

... Later I was told by two other female troops that he had done the same thing to them, and I reported this to the MPs who also interviewed these women. I have since heard of other women that this had occurred to by [redacted] as well, and the one common factor in all those events were normally the women were too drunk to fend him off.

The whole process made me feel that I’d been let down by the system and that the ‘boys club’ once more stuck together and I was valued less. Eighteen years later I submitted a freedom of information request for the MP report, but it’s so heavily redacted that you can’t tell the results of the investigation, so I have still never seen a written result of that investigation and to this day, do not actually know if that was the actual finding.⁸⁰

83. We heard from a victim of gang rape whose ‘plea for help’ was ignored:

My first experience of evil was at the hands of [redacted] who betrayed my trust and the oath that he took. Sexual assault and sexual harassment were not what I joined up for. Reporting the matter that happened at [redacted] was pointless and made matters worse. The chain of command that you were meant to trust in only made things worse and the betrayal even more damaging. My second experience was at [redacted] and that evil was even greater not only to my life but to my state of mind. I was brutally gang raped by those I served with. After reporting to [redacted] police, I was subjected to my chain of command’s betrayal. They did not help me, they ignored my plea for help. They were more concerned with covering up the crime and the image of the Navy instead of doing the right thing. I was subsequently stalked, harassed, bullied until I snapped and my chain

of command forced me to give up my career and leave. And they did everything they could to make that happen. I was the victim but instead I was treated like a criminal for reporting what happened to me. I was never offered any support after leaving the Navy, nor was I advised about my rights where the Department of Veterans' Affairs were concerned.⁸¹

84. According to the DART report, the main reasons for 'reported mismanagement' of abuse that occurred between 2001 to 2011 included no action being taken in response to a report, insufficient action being taken; inappropriate action being taken, including official punishment or disciplining of the victim; and the victim suffering further abuse after reporting.⁸² Mr Robert Cornall AO, Chair of DART from 2014 to 2016, elaborated further:

Well, let's take the example of a young woman who has been raped and she makes a complaint and she's told, 'Well, look, you know, really you shouldn't make a complaint', or, 'I don't believe you', or, 'It's best you don't make a complaint because you will, sort of, rock the boat'. So, yes, I'd understand that she would be very concerned about that. Or they'd say, 'Yes, I'll make an enquiry into it', and then they never hear anything else. So we had very clear evidence for believing that was the situation.⁸³

85. Similar issues persist today. Professor MacKenzie estimates that 80% of people who experience sexual misconduct in the military do not report it.⁸⁴ In response to compulsory notice, Defence estimated an under-reporting rate of 60% for sexual assaults (we note this is a subset of all forms of sexual misconduct).⁸⁵
86. Under-reporting of sexual misconduct has also been demonstrated in information from expert and lived experience witnesses at hearings.
87. For example, a serving member told us about her experience disclosing sexual assault to her chain of command, and the culture of reporting she experienced within the Navy:

I was told by some people that Defence doesn't like paperwork, people don't like doing paperwork, that some people told me that no one would believe me because it ... would be him against me, and I'm a woman, and some people told me that my career was ruined because I couldn't shut my legs ... They were people that were my chain of command so they were meant to, I guess, be there for me and look after me and that's the things that they said to me.⁸⁶

... There was a lot of inappropriate comments made. If we did report the comments or ask for help about the behaviour that was done by the males in our chain of command we were just told that nobody is going to care and we're easily replaced if we are going to cause a scene.⁸⁷

88. Ex-serving Navy member Ms Danielle Wilson was sexually assaulted. Ms Wilson told us nothing was done when she reported the assault:

I still clearly remember going into the office and told, 'Suck it up, princess, it is life in the Navy'. That's when I knew nothing was ever going to be done to anything that ever happened to me. Nothing was done when I was in training, nothing was done then, nothing was ever going to be done.⁸⁸

89. Reverend Dr Nikki Coleman described her experience of reporting sexual misconduct to her manager, who initially failed to take any action in response to her complaint:

So the abuse started in January and I raised it with him in March and his advice at that point was to manage it myself ... because complaints of this nature need to be managed at the lowest level. At that point, I was being assaulted and sexually harassed, plus everything else, bullying. He gave me some suggestions about how to manage my abuser, but at no point did he ever talk about intervening and at no point did I see any intervention or counselling or supervision of my abuser that would have changed the situation. So I met with him fairly regularly because we're both co-located in Canberra, and he had many, many, many opportunities to stop the abuse and he chose not to.⁸⁹

90. Reverend Dr Coleman stated one of her manager's objections to actioning her complaints was that 'it would be unfair to cast aspersions on an innocent man'.⁹⁰

91. We heard similar experiences in submissions from victims of sexual misconduct:

I was afraid to report incidents as I was fearful and afraid of repercussions, my safety, and potential repercussions from the abusers. The culture of Defence Force did not provide a safe avenue to report incidents. As a result of reporting the [redacted] incident I experienced negative consequences. I was ostracised, targeted for harassment, and made to feel like I was the bad person.⁹¹

92. We also heard the repercussions last throughout victims' careers:

During my service I was subjected to years of sexual harassment, including stalking, humiliation, and physical assaults. Shortly after my 18th birthday, I was raped by another member of the Navy, but fearing I would never be believed given previous treatment, I did not bring the matter forward to the Military Police. Despite being the victim of sexual harassment and abuse, I was labelled by female senior staff as a troublemaker and bullied.

The bullying followed me throughout my career until I was able to secure a position in Canberra. As part of the bullying I was coerced into signing a false confession in relation to drug use, which had a significant impact on my career. In making this submission I would like to highlight endemic cultural issues within the Navy relating to the treatment of women, including the impact on them and their reputation when they speak out and report abuse.⁹²

93. Similar barriers have been reported by people who have witnessed sexual misconduct:

I was made aware of alleged sexual harassment and sexual misconduct in my workplace. One of the impacted personnel was my supervisor [redacted] and the respondent was my Director (ADF O6). I called the Sexual Misconduct Prevention and Response Office (SeMPRO) for advice. I was provided advice to support my supervisor and also to report the situation to the Joint Military Police Unit (JMPU).

SeMPRO and JMPU advised that I had a mandatory reporting requirement. I let my supervisor know about my mandatory requirement to report ... She did not want it reported because:

- she didn't want to be 'slut-shamed'
- the respondent is her supervisor and she did not want it to affect her career
- the respondent is well regarded ... and her claims would be dismissed
- she did not want to be treated differently by her co-workers.

... It was also strongly encouraged by some peers that I should not report.

It has been five months since I reported this incident. It has been extremely lonely and I have had some significant mental health issues. I could not believe that in 2023 that I would ever be encouraged to not report sexual harassment and sexual misconduct. I am surprised that I have had to defend the idea that 'mandatory reporting' is mandatory. I do not feel like I belong to my workplace anymore. I am saddened that the culture where I work is not in line with ... ADF values. I am saddened that women do not feel safe enough to report sexual harassment. I am heartbroken that women where I work will endure sexual harassment because it is less of a burden than reporting. It is this situation that lead me to comment to my wife, 'This is why people in Defence try to kill themselves'.

It should not have to be a fight to make sure we have safe workplaces.⁹³

94. Survey data collected by Defence in 2021 identified the five most common reasons members did not report sexual misconduct:

- it would not change things (36.2%)
- I didn't think it was serious enough (30.8%)
- I dealt with the incident directly (25.4%)
- it was easier just to keep quiet (23.6%)
- the instigator was a higher rank – level (23.5%).⁹⁴

95. The IGADF Inquiry referred to this survey data and noted 'there was widespread frustration among commanding officers that victims very often did not wish to make a complaint, even to them'. The Inquiry Report stated:

Commanders considered this denied them the opportunity to intervene early in the case of a minor offender, or to apprehend a perpetrator of a more serious offence who may, if unchecked, go on to repeat that offence.⁹⁵

96. In addition to the reasons given in the survey, the IGADF Inquiry also noted victims provided the following reasons for not reporting sexual misconduct:

- concern about the length of time the process would take
- concern there would be no positive outcome (particularly if the facts in issue related to consent)
- concern if the police investigation did not result in a conviction, they would be 'deemed a liar'
- fear of not being seen as 'a team player', with consequences for promotion and posting
- fear the complaint would not be taken seriously.⁹⁶

97. The 2023 Defence Respect@Work Framework – developed for Defence by the Australian Human Rights Commission following the Respect@Work Inquiry – confirms 'actions should be taken' to address barriers to reporting unacceptable behaviour (including sexual misconduct). It lists similar barriers identified by the DART report, Defence survey data and the IGADF Inquiry.⁹⁷ These include:

- military cultural norms that 'you do not jack (or dob) on your mates'; that you 'maintain solidarity at all costs'; and 'have each other's backs'
- scepticism or lack of confidence that the chain of command would respond sensitively and appropriately, either because the perpetrator was of higher rank than the person reporting, or was friends with someone in the chain of command
- fear that collateral charges (such as alcohol consumption) would be made against a person who reports
- fear of negative consequences for their career, including being labelled a whistle-blower and of other reputational damage
- fear of victimisation from peers and supervisors, and of being ostracised and punished
- leaders using their authority to discourage someone from reporting
- lack of knowledge of where to go for information and support.⁹⁸

98. We agree there are serious risks to both individual victim safety and the broader ADF workforce when sexual misconduct is not reported. While victims should never be forced to report, they must be able to exercise genuine choice when making this decision. This can only occur if the cultural and organisational barriers to reporting sexual misconduct are addressed. The Defence Respect@Work Framework and associated recommendation to address barriers to reporting all forms of unacceptable behaviour is discussed in further detail in Chapter 7, Culture and leadership.
99. We note Defence survey data shows the most common reason for not reporting sexual misconduct is the belief nothing will change. This highlights the importance of the ADF's response when a report is made. This includes the workplace protections that are put in place for victims, the administrative and disciplinary processes to investigate a report, and the consequences for perpetrators when a report is substantiated. These issues are further explored in the following sections.

More victims are seeking advice, but fewer are taking formal action

100. The IGADF Inquiry analysed Defence workforce survey data and found that:

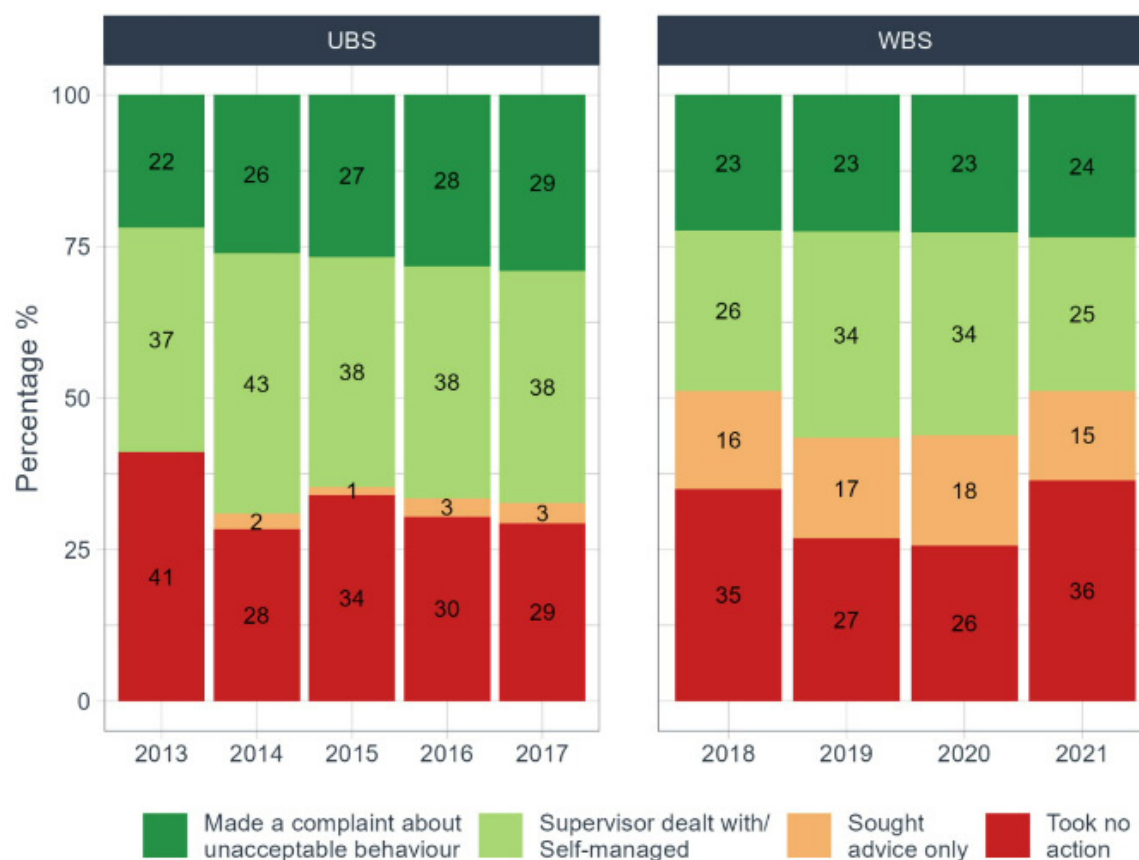
In the case of the ADF ... the proportion of victims who took no action dropped from 41 per cent in 2013 to 36 per cent in 2021, fluctuating slightly in the interim. This is a welcome improvement. However, the proportion of victims who either self-managed the incident, raised it with their commanding officer or made an official complaint also dropped, from 59 per cent in 2013, to 49 per cent most recently; this is of concern for any organisation which relies on reporting to address misconduct.⁹⁹

101. It continued:

since 2013 there has been a significant increase in the percentage of victims who sought advice only; from 2 per cent in 2014 to 15 per cent in 2021. In 2018 a notable shift occurred in the types of actions ADF members were taking after experiencing sexual misconduct. A higher percentage of ADF members sought advice and a lower percentage reached out to supervisors, self-managed their experiences or made formal complaints, compared to previous years.¹⁰⁰

102. These figures are set out in Figure 8.2.

Figure 8.2 ADF members' responses to sexual misconduct (2013– 2021)



Source: Sexual Misconduct in the Australian Defence Force – Perspectives from YourSay Workplace Experiences and the Workplace Behaviours Surveys 2013–2021, Defence People Group, October 2021.¹⁰¹

103. The IGADF Inquiry sought to understand why there was a reduction in actions taken by sexual misconduct victims. It focused on the establishment of SeMPRO in 2013. The Inquiry concluded:

Based on discussions with SeMPRO and Workforce Planning Branch, the inquiry concludes that a restricted disclosure or seeking advice from SeMPRO is a socially focused resolution rather than a formal statutory resolution. The establishment of SeMPRO seemed to empower ADF members to understand their options and make informed decisions about the management of their experiences of sexual misconduct. It has provided an additional avenue for ADF members who are not ready to go through a formal complaints or judicial process to still gain access support and resources they require. The results suggest that subsequent engagement with the formal complaints or judicial processes is less likely to occur. However further research is required to understand why people prefer the 'socially focused approach' versus the 'formal avenues of complaint'.¹⁰²

104. It also noted the role of alcohol in a victim's decision not to proceed with a complaint:

Where alcohol was a factor in the offence, 205 victims (54 per cent) chose not to proceed, compared with offences where no alcohol was present, in which 90 (24 per cent) victims chose not to proceed.

Awareness of the interplay between alcohol and sexual misconduct will also improve ADF members' confidence in the policy. If complainants feel they are entitled to be treated fairly and that their level of intoxication not only does not make them responsible for the unwanted sexual activity but that the law says they were unable to consent to sexual activity, they may be more likely to make a complaint.¹⁰³

105. The IGADF Inquiry made the following finding:

Finding 8. The significant decline in action taken by victims of sexual misconduct may have increased risk to the ADF and to future victims. This outcome requires further investigation.¹⁰⁴

Defence has not investigated why fewer victims are taking action

106. We asked Defence what has been done in response to the IGADF's call for further investigation into the 'significant decline in action' from victims of sexual misconduct. It said:

Defence has not undertaken a separate investigation into Finding 8 of the report.

Defence has focused on implementation of the recommendations of the report, and notes the majority of findings led into the recommendations, and generally a finding is covered by a recommendation.

Defence notes that as this was an IGADF finding (rather than a recommendation), any further investigation would likely be conducted by the IGADF.

Defence notes that actions taken in respect of Recommendations 12 and 13 of the report will also address aspects that could enable any further investigation.¹⁰⁵

107. Recommendation 12 relates to sexual misconduct data sharing within Defence, and Recommendation 13 to developing metrics to understand the impact of sexual misconduct policy. At the time of writing neither of these recommendations had been implemented (see Annexure 8.1 for more detail). It is unclear how they would assist in better understanding why there has been a decline in action by victims. The IGADF Inquiry already provides a data point: the next step is to further investigate why this trend is occurring.

108. After receiving Defence's response, we asked the IGADF what, if any, action it has taken. The IGADF provided the following response:

The IGADF has an oversight role in relation to military justice but, by design, has no executive authority to implement results from oversight activities. [The] IGADF performs this oversight function by, on occasion, directing own-initiative inquiries into particular matters or concerns. In common with all other inquiries, the IGADF own-initiative inquiries are to provide information and potential guidance for consideration, adoption and action by Defence officials who do have executive authority.

It follows that findings and recommendations (and Finding 8 appears to contain both those elements) are not directed at, or actioned by, the IGADF. It further follows that [the] IGADF has not taken action regarding Finding 8, including no further investigations. **In its terms and in the context of the IGADF Inquiry, Finding 8 is aimed at Defence officials with executive authority.**¹⁰⁶

109. To summarise, no action has been taken by Defence or the IGADF in response to this finding, and neither consider it their responsibility to further investigate.

Anonymous reporting is an option

110. The IGADF Inquiry noted that 'restricted disclosures' allow victims to seek support and advice from SeMPRO without triggering notifiable incident reporting obligations. It contrasted this with the United States military's Sexual Assault Prevention and Response Office (SAPRO), which has 'used the relationship-building opportunities provided by restricted disclosures to build the confidence of the victim in reporting the assault'.¹⁰⁷

111. The IGADF Inquiry also referred to the US program CATCH (Catch a Serial Offender), and considered these approaches could increase the number of formal reports from victims:

The US program (Catch a Serial Offender – CATCH), enables Service members and adult dependant victims who file a Restricted Report to anonymously disclose information about their offenders and discover whether the suspect may have also assaulted another person. This information may help inform their decision about whether to convert their report to Unrestricted.

A US survey of victims' use of anonymous reporting is compelling. 'All victims indicated that they would not have reported if the only means had been through a formal report. In 2017, 24 per cent of those reporting went on to convert to a full report initiating an investigation. Key to this is that the report must be recorded to enable an understanding of the level of incidents.'

SeMPRO's role in anonymous reporting and the conversion of anonymous reports to official complaints could be significantly augmented to improve the overall accountability of perpetrators and to improve the enterprise's longitudinal understanding of a perpetrator's behaviour, but in a way which is consistent with a victim-centric approach.

SeMPRO is understandably concerned that greater focus on the conversion of unofficial complaints to formal complaints may cause further trauma to the victim and reduce the victim's sense of control, but the low percentage of incidents which lead to action by Defence suggests this is worthy of consideration.¹⁰⁸

112. The IGADF Inquiry recommended the ADF 'should consider adopting the US program, CATCH, or adopt the US SAPRO's greater use of restricted reports to encourage official reporting'. Defence 'decided to implement the recommendation in full according to its terms'.¹⁰⁹ The recommendation only required Defence to consider adopting the program.

113. Defence has decided not to implement the CATCH program or adopt a greater use of restricted reports, and provided the following rationale for this decision:

It is considered that this approach represents an unacceptable and unmanageable risk to the alleged perpetrator's entitlement to privacy. Additionally, there are concerns about due process since a person previously named as an alleged perpetrator may not have been formally investigated or may have been investigated with a finding of no case to answer.

A trauma informed approach to client wellbeing – in this case the wellbeing of the impacted person – provides that their psychological and physical safety is paramount, as well as their entitlement to make choices, including whether to report or not. The CATCH approach, which may result in an impacted person feeling compelled to report an alleged assault, does not align with trauma informed principles.

The 1800 SeMPRO Client Response Team work with impacted persons to provide the support and advice that they each require, using a person-centred and trauma informed practice framework. This includes advice regarding reporting options which may or may not lead to investigation, depending on the impacted person's wishes. Allowing the impacted person to make the decision to report to JMPU/ CIVPOL [civilian police] on their own terms, without pressure related to other allegations, is the preferred approach as it closely aligns with the core trauma informed principle of choice.¹¹⁰

114. Head of SeMPRO, Group Captain James, confirmed the office did not see any need to consult SAPRO when considering this recommendation. However, Group Captain James did not know how SAPRO addresses concerns about perpetrator privacy or due process.¹¹¹ Nor could she speak to the benefits of the US approach for victims, or potentially reducing safety and wellbeing risk for the broader workforce.¹¹²

115. Defence noted existing JMPU and/or Sexual Offence Response Team (SORT) processes ‘provide the opportunity for the identification of potential serial offenders, and engagement with previously impacted persons to encourage consideration of taking a report to investigation’.¹¹³ Group Captain James gave the following description:

if a member chooses to make a complaint or report but they don’t wish for it to be investigated further ... JMPU are able to identify a name that comes up three times, then they, accessing the support of the SORT team, will approach the impacted individuals to indicate to them that the name has come up before, that there are potential other victims and would they be prepared to pursue a report, you know, in that knowledge? That’s done in that safe, trauma-informed space that the SORT also employs. So ... it’s not the same as CATCH, but we do still have a mechanism to look at an alleged perpetrator’s name coming up more than once.¹¹⁴

116. The SORT was established as a trial in 2019, with one social worker and one dedicated JMPU investigator. Since then, the team has expanded to each of the eight JMPU stations (Canberra, Sydney, Melbourne, Adelaide, Perth, Darwin, Townsville and Brisbane).¹¹⁵ Defence has described SORT’s mission as increasing ‘support to all vulnerable witnesses during the investigative process; empowering individuals to make informed choices and decisions that in turn will have a significant impact upon their recovery process’.¹¹⁶ The IGADF Inquiry found SORT ‘has seen some success in supporting victims to agree to formal investigations of their reports’, based on JMPU data.¹¹⁷

117. Chapter 9 of the Complaints and Resolutions Manual (CARM) says that ‘SORT encourages complainants to formalise their complaint to enable a detailed investigation to occur’. It also states:

JMPU may revisit past complaints where the same person has previously been identified as the alleged suspect in reported sexual offences, and the safety of Defence personnel is directly threatened by their continued presence in the workplace or Service. JMPU will consult SeMPRO, or other relevant providers such as Joint Health Command, to aid assessing all potential impacts on complainants in these cases. This will occur before JMPU makes contact with complainants in past reports for the purposes of gaining their consent for releasing information to the respective Service Chief or their delegate.¹¹⁸

118. We asked Defence about the information provided to victims on the confidential JMPU/SORT reporting option, as it is not clearly explained in CARM or included in any of the fact sheets. Group Captain James advised this information is ‘available via the conversations’ SeMPRO has with victims on reporting options, and the online ‘interactive framework’.¹¹⁹ The interactive framework screenshots provided to us did not include any information about this option, just stating ‘you can report sexual offences to the JMPU’.¹²⁰

119. This reporting option already existed during the IGADF Inquiry, and it does not appear widespread information is available to victims unless they contact SeMPRO directly. Further investigation is therefore needed to determine the level of awareness and efficacy of this reporting avenue.

8.3.2 Data collection and analysis has been a long-term problem

120. The ADF needs to understand the extent of sexual misconduct to tackle it. Data showing its extent and reach is an important initial step for leadership to understand the nature of it and respond appropriately. Unfortunately, there are problems with data the ADF can call on when it comes to sexual misconduct. That is despite it knowing of the issues for more than a decade.
121. In 2012, the Broderick Review identified inadequacies in data collection and the strategic use of data in relation to all forms of sexual misconduct in Defence.¹²¹ The Broderick Review report observed that:

an accurate picture of the extent of sexually based unacceptable behaviour cannot be ascertained. This means that offenders cannot be tracked, repeat offenders cannot be identified, outcomes cannot be measured for their appropriateness and the level of risk to other ADF members cannot be determined and addressed.¹²²

122. In November 2020, the Audit and Fraud Control Division commissioned Axiom Associates to assess the appropriateness of Defence's overall framework for managing the risk of sexual misconduct. The audit report stated:

Fragmented business information is impeding the evaluation of prevention, detection and response measures.

Sexual misconduct incident data is ... fragmented, as information contained in disparate systems is siloed along functional lines, with no automated mechanism to integrate the available intelligence. The ability to share information or build a consolidated, holistic view of the enterprise environment is therefore problematic.¹²³

123. Recommendation 2 in the report was that:

Defence People Group design an evidence-based approach to monitor and evaluate the effectiveness of the sexual misconduct framework. This should be supported by ... the consolidation of incident related data to facilitate the tracking and reporting of trends and intelligence at the enterprise level.¹²⁴

124. The report stated that SeMPRO had ‘previously recognised a gap in a consolidated enterprise-level view of Defence’s data holdings and undertook some informal activities to report information’.¹²⁵ However, it said:

SeMPRO is neither resourced, nor do they currently have the capacity, or capability to perform this oversight function. Defence People Group must therefore assign accountability and responsibility of data consolidation to an appropriate owner to allow for effective oversight of Defence’s information holdings.¹²⁶

125. Despite this, SeMPRO was allocated responsibility for implementing the recommendation, and it established a sexual misconduct data-sharing forum (co-chaired with JMPU) to progress this work.¹²⁷

126. In 2021, the IGADF Inquiry made similar observations to the audit report:

[Sexual misconduct] Data available from these various sources is presented with varying levels of clarity. Findings are rarely accompanied by policy recommendations, for the reason that no one directorate or unit has sufficient line of sight to other sources of data to be able to do so with confidence. The collection of data related to sexual misconduct is a scattering of jigsaw pieces that have not yet been put in place to form the whole picture.¹²⁸

127. It noted SeMPRO had been allocated the data consolidation task, and reported:

There is no centralised integration of data relating to the management of sexual misconduct, although this is expected to change. The newly established Data Division will be responsible, as part of its 2023 onwards strategy, for ensuring that integrated data analysis is reliably able to support policy monitoring and reform.¹²⁹

128. However, the recommended consolidation of sexual misconduct data did not occur and the data-sharing forum was closed, partly due to barriers to sharing data between different areas of Defence.¹³⁰ Associate Secretary for Defence Mr Matthew Yannopoulos PSM told us the key barriers related to consent and exacerbating trauma and privacy. Defence wanted to ensure it did not ‘re-harm individuals who have given trust that we will manage their incident in a confidential way’. However, the Associate Secretary was unaware whether Defence had compared the risks associated with integrating the datasets against the risks associated with the status quo.¹³¹ We note Defence’s Enterprise Data Sharing Framework explicitly recognises that the risks of not sharing data may outweigh the potential risks of sharing it, which is further discussed in Chapter 29, Use of data and research by Defence and DVA.

129. At the time of writing, Defence still did not have a reliable integrated dataset for sexual misconduct. As a result, the ADF cannot effectively understand the extent of sexual misconduct, nor measure the effectiveness of policies aimed at responding to or preventing sexual misconduct.¹³² Given the significant impacts of sexual misconduct on individuals and the broader workforce, including military capability, and the known links to suicide and suicidality, this is unacceptable.

130. Associate Secretary Yannopoulos conceded the Data Division has failed to ensure integrated data analysis can support sexual misconduct policy monitoring and reform.¹³³ He agreed it is unacceptable that four years after Defence's own Audit and Fraud Control Division recommended consolidating sexual misconduct data, 'no meaningful progress has been made'.¹³⁴
131. The failing will be partially solved by the CASE management system's introduction in May 2024, further discussed in Chapter 10, The ADF military justice system. CASE will enable Defence to look across the ADF's administrative and disciplinary systems to capture information on the number of incidents and their management.¹³⁵ However, Defence acknowledges the breadth of datasets that need to be integrated to provide a comprehensive view of sexual misconduct:

Sexual misconduct is a complex issue. No single data source can provide all of the information needed to assess the prevalence of sexual misconduct. Data must be drawn from various sources across Defence to understand the nature of sexual misconduct in Defence. This requires access to data on incident management, administrative and disciplinary action and investigations, health provision, behaviour surveys, civilian and military police action, code of conduct action, culture initiatives, workplace health and safety data, research, unacceptable behaviour reporting more broadly, and measures of risk and protective factors to name a few. More importantly this requires for the collective data to be analysed in order to make informed judgements about trends and provide advice on where Defence should best target its sexual misconduct prevention initiatives.¹³⁶

132. Defence informed us the unfinished work of the sexual misconduct data-sharing forum would be integrated into a 'newly appointed Unacceptable Behaviours Reporting Working Group to develop [an] interface solution, with resourcing considerations to be presented to the DPC [Defence People Committee] in mid-2024'.¹³⁷ Its 'dashboard interface', which is still in development, is intended to draw together unacceptable behaviour data from different sources, including the new CASE system. Associate Secretary Yannopoulos said it will 'enable drill-down and a longitudinal analysis of unacceptable behaviour data' via an 'online system that staff will be able to navigate in to explore what's going on'.¹³⁸
133. He acknowledged the same barriers to sharing and consolidating sexual misconduct data identified by the SeMPRO data-sharing forum will likely be an issue for the unacceptable behaviour dashboard interface. However, Associate Secretary Yannopoulos said:

that does not mean you can't bring this data together, [without] showing individual unit record data to enable us to investigate areas or units that have a higher prevalence of unacceptable behaviour.¹³⁹

134. The Associate Secretary confirmed Defence was working through the barriers, but did not know why this work had not been done earlier. Nor could he confirm whether the interface would enable Defence to assess the effectiveness of its sexual misconduct framework, and fully implement the 2020 audit recommendation to consolidate data and enable effective oversight, as it was still a work in progress. But this was the intention.¹⁴⁰

135. It is positive that work is still underway to integrate and consolidate sexual misconduct data across Defence, but the consequences of delays to date are significant. Group Captain James confirmed that an accurate picture of sexually based unacceptable behaviour is 'essential for prevention efforts to understand the extent of the issue'.¹⁴¹ Similar observations were made by Professor MacKenzie:

... I can't imagine how you could solve a problem that you don't understand the nature of it. So I think it's very difficult to know, for example, where most of these assaults or forms of violence are happening. Are they happening on rural posts, or the rank of perpetrators, for example. There are key pieces of data that are missing that would help to initiate targeted solutions ... it is impossible to understand the extent of the problem, given the means of data collection over the past 20 years.¹⁴²

136. Professor MacKenzie contrasted the ADF's practices with the US Armed Forces:

They collect data on the rank of the perpetrators, what happens when an incident is reported, whether it is reported formally or informally, what is the outcome of that, the location of the incident, the career trajectory of that victim. So there is so much more extensive data and it has resulted in a greater understanding of the problem and understanding particular bases or posts that have very high levels of sexual assault and sexual violence, so there can be targeted responses.¹⁴³

Public reporting is limited

137. Different parts of the ADF and the military justice system collect and publish data relating to types of sexual offences and/or misconduct. However, they do not provide information in the same way or format.
138. They have different definitions for key terms, and report on different types of conduct and offences. Only some disaggregate their data so it is clear what offences they are reporting on. Some reports are on a financial year basis and others based on a calendar year – and cases are not 'rolled-over' year to year so outcomes can be tracked.

Annual reports only provide data on reported sexual assaults

139. Professor MacKenzie raised concerns about ADF's 'data collection of military sexual violence', including the limited information in annual reports:

The data is collected in an inconsistent, sometimes baffling manner. Over the past two decades, at least, data has not been collected consistently. It hasn't been made publicly available consistently ... The annual report that Defence puts out, really the reports focus on sexual assault, so even they aren't using the term that they set out. So sexual misconduct is a key focus but really in the annual reports we only get data on ... sexual assault.¹⁴⁴

140. Defence annual reports include the number of aggravated and non-aggravated sexual assaults in the ADF reported to JMPU. It uses the Australian and New Zealand Standard Offence Classification – however, this definition is not used in any policy guidance or training material. ‘Aggravated’ sexual assaults include sexual intercourse, inflicting injury or violence, the possession or use of a weapon, assaults committed against a child, and those committed by two or more people.¹⁴⁵
141. Annual reports also include the number of cases in which victims did not want to make a statement of complaint or have JMPU or civilian police investigate the matter, and the number of complaints withdrawn. The number of complaints not progressed at the victim’s request are reported in totals, and are not disaggregated by offence type. Annual Report figures from 2018–19 to 2022–23 are summarised in Table 8.2.

Table 8.2 Sexual assaults reported to JMPU 2018–19 to 2022–23

	2018–19	2019–20	2020–21	2021–22	2022–23	Total
Aggravated sexual assaults	79	88	116	88	64	435
Non-aggravated sexual assaults	87	73	71	60	69	360
Total sexual assaults	166	161	187	148	133	795
Complaints not progressed	75 (45%)	76 (47%)	83 (44%)	71 (48%)	58 (44%)	363 (46%)

Note: The sexual assault figures are drawn from a live policing database and reflect JMPU’s understanding of matters as at July each year. These figures are initial reports and may change as they are investigated or finalised.

Source: Department of Defence, *Defence Annual Report 2018–19*, p 122 (Exhibit 17-03.013, Hearing Block 3, DVS.0000.0001.3099; Department of Defence, *Defence Annual Report 2019–20*, p 143 (Exhibit 17-03.020, Hearing Block 3, DVS.0000.0001.3384); Department of Defence, *Defence Annual Report 2020–21*, pp 140–141, (Exhibit 16-01.031, Hearing Block 3, DVS.0000.0001.3686); Department of Defence, *Defence Annual Report 2021–22*, pp 143–144 (Exhibit 69-03.017, Hearing Block 10, DEF.1151.0005.0032); Department of Defence, *Defence Annual Report 2022–23*, pp 114–115, (Exhibit I-01.004, DVS.2222.0001.5087).

142. As these are point-in-time figures, the actual number of complaints not progressed may be higher. We are therefore unable to draw any firm conclusions on the basis of this data alone, other than to observe that:
- Close to 800 sexual assaults have been reported in the ADF over the past 5 years. This is extraordinarily high by any measure, particularly in the context of Defence estimating an under-reporting rate of 60% for sexual assaults.¹⁴⁶
 - A large number of sexual assault complaints are not progressed each year, at the victim’s request.

Public reporting on outcomes and sanctions is difficult to analyse

143. Public reporting for disciplinary outcomes does not provide clear and accessible aggregated information on sexual offence convictions and the sanctions applied.
144. Annual reports provide a point-in-time breakdown of sexual assaults reported in the financial year. For example, the 2022–2023 Annual Report included the following information:

The policing outcomes of the 133 reported sexual assaults were:

- 53 cases where ADF personnel did not wish to make a statement of complaint or have the matter investigated by civilian or military police
 - five cases where the complaint was withdrawn (four cases with civilian police and one case with military police)
 - 10 cases where there was insufficient evidence to proceed (five cases with civilian police and five cases with military police)
 - 12 cases where there was no ADF jurisdiction as the alleged offender was a civilian, ADF cadet, former ADF personnel, personnel of another military force, or the victim indicated they wanted the civilian police to investigate and did not want Defence to be provided any details;
 - 48 cases remained ongoing investigations with civilian police (28 cases), ongoing investigations with military police (nine cases), or are with the Office of Military Prosecutions (11 cases)
 - three cases resulted in guilty outcomes at a military trial
 - one case resulted in an administrative sanction
 - one case ended with no further action.¹⁴⁷
145. However, the report only captures outcomes for sexual assault complaints made in the same financial year. This makes it impossible to assess how many complaints actually proceed to trial and/or result in administrative and disciplinary action, as there is no roll-over reporting from one year to the next. It also doesn't enable analysis of each service, as results are reported at the ADF level. The report is also silent on complaints regarding other forms of sexual misconduct, including sexual harassment and non-assaultive offences (that is, offences of a sexual nature that do not involve physical contact) that do not meet the 'sexual assault' offence threshold.
146. Similar issues apply to reports on the disciplinary system. The Director of Military Prosecutions reports annually on the number of 'sexual assault and related offences' by service that were 'dealt with' during the reporting period.¹⁴⁸ However, these reports are produced on a calendar year basis, unlike annual reports, which are on a financial year basis. The total numbers of matters that were not prosecuted, referred for trial or carried over to the next year are provided, but are not broken down by offence type.

147. The outcomes of superior service tribunal proceedings are published on a rolling basis for the previous 2 years in the form of individual case summaries.¹⁴⁹ However, there is no aggregated reporting that enables analysis of the types of punishments issued for sexual offence convictions.
148. The Judge Advocate General publishes the outcomes of disciplinary matters in Defence Force Discipline annual reports. However, it is not possible to identify how many sexual offence prosecutions resulted in convictions, or the relevant punishments applied. The reports only list offences under section 61 of the *Defence Force Discipline Act 1982* (Cth) (DFDA), 'Offences based on Territory offences', which are broader than sexual offences.¹⁵⁰
149. Nor does the presentation of data in these reports enable any meaningful analysis of convictions, the service and rank of offenders, or the punishment that was applied, as each of these datasets are reported completely separately. It is unclear what use this data serves in the current format, for sexual offences or DFDA offences more broadly. The IGADF Inquiry made a similar observation:

The results of courts-martial or Defence Force magistrate trials are not published in a form that is easily accessible and there is no redacted or summary account of administrative actions taken against those who have perpetrated sexual misconduct available to members. The deterrent effect of punishment of offenders is consequently minor.¹⁵¹

150. The investigation, prosecution and sanctions for sexual offences is further discussed in section 8.5.

8.3.3 Comparisons with other workplaces can downplay the problem

151. The Defence Respect@Work Framework states that 'sexual harassment [which in this context means all forms of sexual misconduct] is more prevalent in some workplaces than others'. They include 'male-dominated industries' and 'industries that are characterised by hierarchical workplaces', such as 'defence organisations'.¹⁵² However, comparisons between the prevalence of sexual misconduct in the ADF and other organisations or industries have often sought to downplay the extent of the problem.
152. The *Women in the Australian Defence Force (ADF) 2021-2022 Ten Years in Review* report said the rising trend of sexual assault from 2013 to 2022, and that women are disproportionately victims, 'aligns with national data and trends'.¹⁵³ The SeMPRO 2021–22 annual report also compared the increase in support clients to population-level data:

The increased demand seen in Support clients has taken place in the context of continued elevated call rates to national Australian call centre services, such as Lifeline and Beyond Blue. Nationally, the elevated call rates are due in large part to the psychological distress from the 2019 bushfires, flooding during 2021–22, and the ongoing impacts of the COVID–19 pandemic.¹⁵⁴

153. It is unclear what, if anything, connects increased demand for support from victims of sexual misconduct in the ADF to increased calls to mental health support lines that were primarily related to the COVID-19 pandemic, bushfires and floods. Group Captain James said SeMPRO experienced an increase in the number of support clients in this period because ‘people were becoming more aware of what sexual misconduct or sexual harassment, sexual assault is within the community and, in line with that, so was Defence’.¹⁵⁵
154. While we agree that sexual violence is a problem in the broader Australian community, using this as a basis for comparison fails to acknowledge that the ADF is a workplace. Group Captain James conceded that comparing figures of sexual misconduct in the ADF with those in other workplaces would be a more relevant and appropriate comparison than using general population data.¹⁵⁶
155. However, even when comparing the prevalence of sexual misconduct in the ADF with that in other workplaces, significant care needs to be taken. In 2020, the Australian Human Rights Commission (AHRC) found the Defence workplace behaviours survey captured a narrower range of sexual misconduct behaviours compared to the national workplace sexual harassment survey. The AHRC recommended Defence review the unacceptable behaviours listed in its survey to include a wider range of behaviours.¹⁵⁷ Issues relating to Defence’s workplace survey program are discussed in Chapter 29, Use of data and research by Defence and DVA.
156. Then in 2022, the AHRC warned Defence against comparing prevalence results between different surveys where they captured different – and in Defence’s case, fewer – behaviours. A 2022 report the AHRC produced for the Navy, entitled *Sexual Misconduct Insights*, stated:

Comparing prevalence results between surveys using different methods may provide a misleading picture. For example, in 2018, Defence’s Workplace Behaviours Survey (WBS; the most recent version to which the Commission has access) estimated a sexual misconduct rate of 5% amongst Defence personnel, while the 2018 National Survey estimated 20% sexual harassment across the Australian workforce as a whole. **Rather than suggesting that sexual misconduct is less of a problem in Defence than in civilian workplaces, the disparate results are likely due to different survey methods.** This includes the WBS survey asking about a far narrower range of unwelcome sexualised behaviours. There are at least six behaviours in the Commission’s survey for which there was no equivalent in the WBS.¹⁵⁸

157. The IGADF Inquiry into sexual misconduct also noted that ‘survey results are not directly comparable’ and ‘future comparisons ... would benefit from an agreed approach to the prevalence period and the behaviours included’, echoing the AHRC’s concerns.¹⁵⁹

158. In addition to the ADF's narrower definition of sexual misconduct, national survey results have been misinterpreted. The AHRC survey of civilian workplaces uses the term 'sexual harassment' to describe a broad range of unwelcome sexualised behaviours, including sexual assault and other forms of sexual abuse.¹⁶⁰ In Defence, these behaviours are collectively described as sexual misconduct. However, the IGADF Inquiry incorrectly interpreted 'sexual harassment' to have a much narrower meaning (the legal definition of it used in Defence terminology) when comparing survey results, thereby downplaying the extent of sexual misconduct in the ADF:

Today, the prevalence of sexual misconduct in the ADF (which includes sex discrimination, sexual harassment and sexual offences) stands at 5.7 per cent, compared with 20 per cent (for harassment incidents only) in Australia's civilian workplaces.¹⁶¹

159. This finding was included in a briefing to the Minister for Defence in August 2022 in response to the Minister's request for an inter-jurisdictional comparison of sexual misconduct.¹⁶² It was also included in the draft Defence Sexual Misconduct Prevention and Response Strategy, dated May 2024.¹⁶³ During procedural fairness, Defence conceded this error and confirmed it has addressed it.¹⁶⁴
160. As we discuss in section 8.3.2, the ADF's urgent priority is to ensure it has a robust internal dataset that can accurately measure the prevalence of all forms of sexual misconduct and inform prevention and response efforts. Any comparisons with other workplaces should only be based on comparable data. In addition, comparisons should not undermine the sense of urgency required to reduce the occurrence of sexual misconduct in the ADF, given the significant impact on victims and flow-on effects to military capability.

8.4 Sexual misconduct policies, systems and training

161. The main source of guidance for ADF personnel and its leaders around what constitutes sexual misconduct and how to manage it are through policy documents and workshops and training. Our examination has found a lack of clarity about what constitutes an offence and what commanders and managers should do when a report is made. We also noted a low uptake of training designed to ensure commanders and managers can appropriately respond when they receive a report.

8.4.1 Policy guidance lacks key definitions

162. The Complaints and Resolutions Manual (CARM) provides policy guidance on reporting and managing sexual misconduct. Chapter 3 relates to all forms of unacceptable behaviour, and Chapter 9 is specific to sexual misconduct. Sexual misconduct spans 'sex discrimination, sexual harassment, and sexual offences'.¹⁶⁵

There is no clear definition of what constitutes a sexual offence

163. CARM clearly defines ‘sex discrimination’ and ‘sexual harassment’ in Chapter 9:

Sex discrimination occurs when a person is treated less favourably than another person in the same or similar circumstances because of that person’s sex, characteristics of that person’s sex, or assumed characteristics of that person’s sex. The *Sex Discrimination Act 1984* contains a detailed definition. The *Sex Discrimination Act 1984* additionally makes it unlawful to discriminate on the grounds of sexual orientation, gender identity, intersex status, marital or relationship status, pregnancy or potential pregnancy, and breastfeeding or family responsibilities.

Sexual harassment occurs when a person makes unwelcome sexual advances, requests sexual favours, or engages in other unwelcome sexualised conduct, in circumstances reasonably anticipated to offend, humiliate, or intimidate. Sexual harassment is unlawful under the *Sex Discrimination Act 1984*.¹⁶⁶

164. However, its definition of a ‘sexual offence’ is much less clear. Chapter 3 describes sexual offences as:

criminal actions that are also unacceptable behaviour which may warrant action under the *Defence Force Discipline Act 1982* or other Commonwealth legislation. There are a number of different types of sexual offences, which can often be described using different terms. Although sexual offences are unacceptable behaviour, they are to be managed in accordance with Chapter 9 – Responding to Sexual Misconduct.¹⁶⁷

165. Chapter 9 has a different definition:

Sexual offences are acts, or intent of acts, of a sexual nature against another person, which are non-consensual. Sexual offences are defined in various Commonwealth, state and territory legislation. Specific offences differ across the various jurisdictions but are broadly categorised as sexual assaults and non-assaultive sexual offences.¹⁶⁸

166. In both cases, sexual offences are generally defined by high-level references to legislation and offence categories. They fail to clearly explain the acts or behaviours that constitute an offence. In contrast, CARM provides a detailed description of what constitutes intimate image abuse and stalking offences, even though there are technical differences between jurisdictions:

Intimate image abuse occurs when a person takes, views, or distributes intimate images of another person without their consent. Intimate images span still or moving images of a person's genital or anal areas, and breasts for female and female-identifying people; depicting a person engaging in a private act; depicting a person in a sexual manner or context; and includes any images altered to appear to show any of these things. Some intimate image offences are grouped within sexual offences in state and territory legislation. Others are contained within separate offence categories in state and territory legislation and in the *Criminal Code Act 1995*.

Stalking offences, including actions undertaken using electronic communication methods, are categorised as a separate offence category in state and territory legislation. Stalking actions are those amounting to intimidation, harassment, or molestation, undertaken more than once, that are reasonably expected to cause apprehension or fear of harm. Stalking spans actions such as following, watching, loitering near, keeping under surveillance, sending offensive material, interfering with property, sending electronic messages to or about the stalked person, or acting covertly in another way reasonably anticipated to cause apprehension or fear.¹⁶⁹

167. SeMPRO Assistant Director, Education Development, Ms Katie Urquhart told us there were difficulties providing members with a detailed definition of a sexual offence. This was because 'jurisdictional law applies to all our members as well as ACT law, so it's very hard to narrow down a single definition when every law is individually based'.¹⁷⁰ Asked why CARM then includes detailed descriptions of intimate image abuse and stalking, Ms Urquhart said these offences are 'prosecuted under jurisdictional law where the DFDA [*Defence Force Discipline Act*] can apply a Defence policy'.¹⁷¹ However, sexual offences also fall into this category. That is, if Defence prosecutes under the DFDA, then the *Crimes Act 1900* (ACT) applies; or if civilian police prosecutes, it is under the relevant state and territory law. It is still unclear why a different approach is taken to defining them.
168. The Defence Respect@Work Framework states that 'a lack of awareness or understanding' of sexual misconduct contributes to it happening in the workplace.¹⁷² This underscores the importance of clearly defining the types of acts or behaviours that amount to sexual offences.
169. We see no reason why CARM should not include definitions of sexual offences aligned to those under the *Crimes Act 1900* (ACT), which are the basis for prosecuting sexual offences under the DFDA. Similar to the approach taken to intimate image abuse and stalking, these definitions should clearly describe the types of behaviour and actions that constitute each offence, and note that each state and territory may have different technical definitions.

Guidance for managers and commanders is confusing

170. One commanding officer commented to the IGADF Inquiry that ‘Command training is good, but under pressure, people need clear, simple instructions’.¹⁷³ We agree. This is particularly important in the context of sexual offences, where the collection of forensic evidence is time-critical, and a trauma-informed approach should avoid asking victims to give a detailed description of an incident multiple times. However, the guidance provided to managers and commanders receiving sexual misconduct reports has the potential to cause confusion.
171. Chapter 3 of CARM states that ‘suspected cases of sexual misconduct must be managed in the first instance in accordance with Chapter 9’. Then, ‘when the incident is a sexual offence’ a Defence Investigative Authority – that is, JMPU – must be contacted before fact finding begins (that is, the Defence initial inquiry process). (See Chapter 10, The ADF military justice system, for information about fact finding processes).¹⁷⁴ Chapter 3 includes a ‘flowchart for responding to incidents of unacceptable behaviour’, which provides the following instructions to commanders and managers:

Does the complaint involve allegations of sexual misconduct, including a sexual offence?

Yes: Contact Joint Military Policing Unit (JMPU) for advice on how to manage complaint.

Contact Sexual Misconduct Prevention and Response Office (SeMPRO) for advice on providing support.¹⁷⁵

172. This seems to make it clear to contact JMPU for advice when a sexual misconduct report is received. However, Chapter 9 gives the following guidance:

Commanders and managers who receive a report about sexual misconduct will need to assess whether an incident is possibly a criminal offence, a sexual harassment incident, or sex discrimination, based on the complainant’s description or by contacting JMPU for advice if there is uncertainty. The type of incident will determine any subsequent actions to be undertaken, which may include criminal or disciplinary actions for offences. People subjected to sexual misconduct may not initially provide comprehensive details of the incident which can make it difficult to assess the nature of events. Any fact finding must cease as soon as an incident is identified as a possible criminal offence.

In most cases it is inappropriate to commence a fact finding process to determine the nature of a sexual misconduct allegation without discussing that step with JMPU first. Asking the complainant to provide a single account to a trained investigator if the matter is a sexual offence, rather describing it multiple times in multiple processes, avoids risks of further psychological harm to the individual and potentially undermining an investigation.¹⁷⁶

The first recommended action after receiving a complaint for sexual harassment or sex discrimination is to consult JMPU to ensure that the alleged incident is not an offence.¹⁷⁷

173. It appears that different parts of Defence also have mixed views on whether managers and commanders should consult JMPU on all reports of sexual misconduct.
174. Head of SeMPRO, Group Captain Fleur James, said there is ‘not a requirement to call JMPU for every single report of a sexual misconduct, but if it’s not clear if it’s a sexual offence, then, yeah, contact JMPU for clarification’.¹⁷⁸ However, this requires commanders and managers to have a clear understanding of what constitutes sexual harassment, sex discrimination and sexual offences. Group Captain James also said she believes the Foundation of Knowledge (mandatory general awareness) training is very clear on definitions.¹⁷⁹ This training is discussed in section 8.4.2 and was only made mandatory in 2023.
175. We asked Defence whether managers and commanders who receive a report of sexual misconduct should first contact JMPU officers for advice on whether the alleged conduct is an offence. Defence responded:

JMPU Officers are trained to identify and categorise disciplinary and criminal offences. For that reason, JMPU agrees that the recommendation in Chapter 9, Part 6, paragraph 16 of the CARM [that is, the extract quoted above that states ‘the first recommended action ... is to consult JMPU’] is appropriate because JMPU officers are more readily able than other personnel to provide certain information in response to information being reported including whether the alleged conduct could constitute an offence.

Furthermore, by having managers and commanders discussing the matter with JMPU, when an offence is indicated, it enables an early conversation with the victim and prevention of the possible destruction of evidence related to the investigation through potential broader exposure and delays to the reporting.¹⁸⁰

176. We agree with this, particularly given the need to ensure evidence is preserved and collected in a timely way. CARM Chapter 9 should be amended to provide clear and explicit instructions that all sexual misconduct reports should be discussed with JMPU to determine whether the conduct constitutes an offence, before any further action is taken.

Recommendation 15: Clarify definitions and processes related to sexual offences

Defence should amend its Complaints and Resolutions Manual to:

- (a) include definitions of sexual offences aligned with the *Crimes Act 1900* (ACT) sexual offence provisions, that clearly describe the types of behaviours and actions that constitute each offence
- (b) provide clear and explicit instructions that managers and commanders who receive a report of sexual misconduct should consult with the Joint Military Police Unit to determine whether the conduct constitutes an offence, before taking any further action.

8.4.2 Sexual misconduct training for leaders

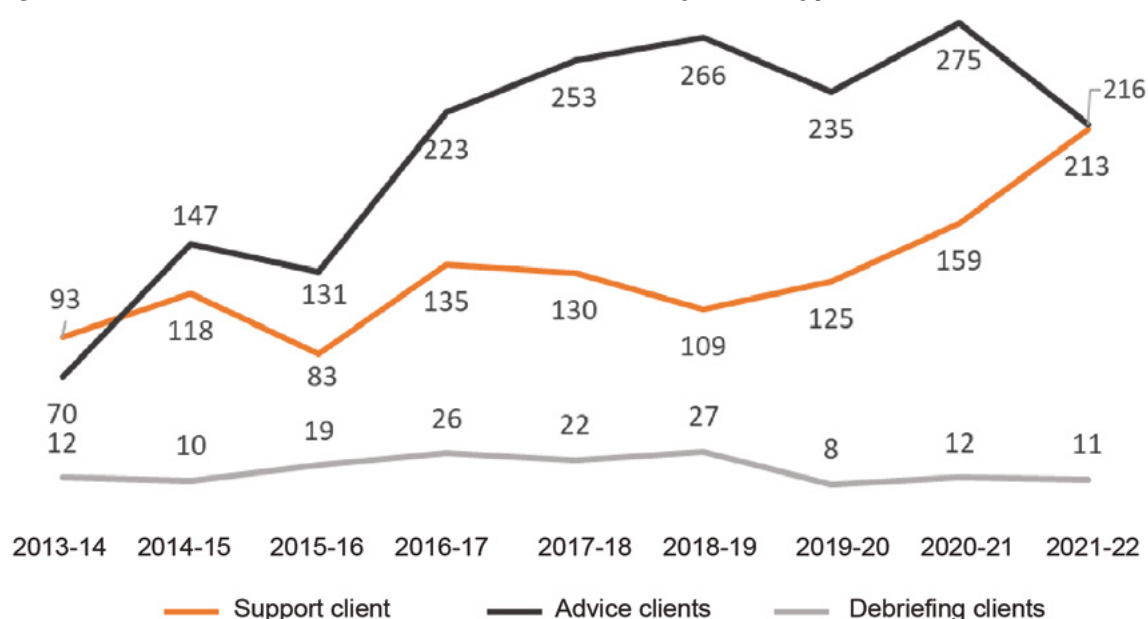
177. Reported sexual harassment or sex discrimination (that is, behaviours considered to be sexual misconduct but not a sexual offence) are managed as unacceptable behaviours, although specific processes apply. Commanders and managers managing sexual harassment or sex discrimination incidents at a unit level are to establish the known facts and undertake fact finding where further action is required.¹⁸¹ Commanders and managers may also receive reports of sexual offences, which JMPU investigates.
178. SeMPRO experienced an increase in demand from ‘advice’ clients, that includes commanders and managers, between 2013–14 and 2021–22:

Longitudinal analysis has identified a shift from predominantly delivering services to people directly impacted by sexual misconduct (Support clients) to those around them who are seeking advice on how to provide an impacted person with the best response possible (Advice clients). The proportion of clients seeking support services after being subjected to sexual misconduct has been made up of less than half of the total number of SeMPRO clients each year since 2013–14. Support clients made up 53 per cent of all clients in 2013–14 and have since varied between 27 per cent in 2018–19 and 48 per cent in 2021–22.

Clients calling for advice on responding to a disclosure or to a report have been the largest client group in each year since 2013–14.¹⁸²

179. SeMPRO’s 2021–22 Annual Report shows a decrease in advice clients and an increase in support clients (see Figure 8.3). However, it is too early to tell if this indicates a reversal in the overall trend from 2013–14 to 2021–22.

Figure 8.3 SeMPRO new clients from 2013–2022 by client type



Source: Department of Defence, *Sexual Misconduct Prevention and Response Office Annual Report 2021–22*, 2022, p 6 (Exhibit 90-06.024, Hearing Block 12, DVS.0012.0001.0636).

Few have attended sexual misconduct workshops

180. SeMPRO delivers workshops tailored to different cohorts responsible for managing sexual misconduct incidents, or who are likely to receive disclosures due to the nature of their role:

The **Sexual Misconduct Incident Management workshop** is designed for decision makers. The workshop outlines the policy and legal requirements in allegations of criminal and non-criminal sexual misconduct. It guides participants to generate strategies that both employ a person-centred and trauma-informed approach toward the impacted person, while also navigating the incident management process in Defence's unique work environments.

The **Sexual Misconduct Incident Response and Wellbeing workshop** was launched in 2021. It is for personnel who, because of their rank or their role, may receive a disclosure about sexual misconduct but do not directly manage incidents or have decision making responsibilities. This workshop offers detailed guidance on how to provide support for an impacted person using a trauma-informed person-centred approach. There is also instruction on Defence policy requirements, including reporting obligations.

Sexual Misconduct Incident Response and Management for Chaplains helps to equip ADF Chaplains when receiving disclosures in Defence. Chaplains have a particular role of trust in the organisation and may be a first point of disclosure for an incident. The workshop teaches blending chaplains' existing knowledge and experience in providing pastoral care with Defence environments, services, and policy requirements.¹⁸³

181. The SeMPRO 2021–2022 annual report states that 1% of all Defence personnel were proficient in the Incident Management and Incident Response and Wellbeing workshops.¹⁸⁴ However, these workshops are not intended for all personnel, so these figures are relatively meaningless.
182. We asked Defence to identify the roles and provide the corresponding workshop attendance rates for personnel who are responsible for managing and/or responding to sexual misconduct incidents. Defence provided the figures in Table 8.3 of the 'percentage of personnel with responsibility [for managing or responding to sexual misconduct] who are current' in the workshops by rank and service.¹⁸⁵

Table 8.3 Sexual misconduct workshops attendance rates at 30 June 2023

Service	Total percentage	EO4–E10 (non-commissioned officers, corporal–warrant officer) (%)	O–1 to O–3 (2nd lieutenant–captain) (%)	O–4 or higher (major or higher) (%)
Sexual Misconduct Incident Management Workshop (for decision-makers)				
Navy	2.2	0.7	3.3	5.1
Army	0.1	0.1	0.0	0.3
Air Force	0.8	0.3	0.2	2.4
Sexual Misconduct Incident Response and Wellbeing Workshop				
Navy	6.5	9.6	4.0	1.1
Army	0.7	0.5	1.8	0.4
Air Force	1.3	1.6	1.2	0.9

Source: Exhibit 90-06.003, Hearing Block 12, Department of Defence, Response to NTG-DEF-259, DEF.9999.0167.0001 at 0003–0004.

183. SeMPRO's Ms Urquhart agreed these percentages are 'incredibly low'. She said this was because the figures include 'everyone within the ADF that is corporal or above, because anyone in that role' could receive a disclosure. Ms Urquhart said SeMPRO was addressing this through a new Application of Knowledge module on peer responses to a disclosure, which will promote a 'Defence-wide understanding of a similar concept'.¹⁸⁶
184. However, Ms Urquhart conceded that peers have different responsibilities from those of commanders and managers when receiving a disclosure of sexual misconduct.¹⁸⁷ This is a critical distinction. Commanders and managers are decision-makers and have legal responsibilities and duties to fulfil in interacting with the victim and the alleged perpetrator, and maintaining the safety of the broader team or unit.
185. Despite this, it is not compulsory for commanders and managers to attend the workshop for decision-makers. Ms Urquhart agreed that it was preferable that managers and commanders could provide a proactive trauma-informed response when someone discloses sexual misconduct, rather than having to contact SeMPRO first for advice, but could not say why the workshop is not mandatory.¹⁸⁸

186. SeMPRO encourages the individual services to incorporate the training workshops into their courses, but it does not have the power to mandate that commanders attend them.¹⁸⁹ Defence told us the Sexual Misconduct Incident Management Workshop (for decision-makers) has been ‘routinely delivered’ to the following cohorts over the past 5 years:

RAAF Commanders Seminar (RAAF School of Postgraduate Studies)

RAAF Squadron Warrant Officer course (RAAF School of Postgraduate Studies)

RAN Commanding Officer/Executive Officer Designation course (HMAS Watson)

RAN Command Warrant Officer course (Garden Island)

RAN Engineering Officer Designation course (HMAS Cerberus).¹⁹⁰

187. It is a very short list and contains no Army courses. Given the impact of sexual misconduct on victims’ physical and mental health, and the link to suicide and suicidality, it is essential Defence trains decision-makers in how to respond with skill and confidence. It is positive that SeMPRO provides one-on-one support, but this should not be the default.

ADF has not formally evaluated workshops

188. The 2021 IGADF Inquiry found:

There is considerable dissatisfaction with the nature of training provided for the management of sexual misconduct. Training in the management of sexual misconduct should be reviewed to ensure it is interactive, engaging and provides relevant information about outcomes of complaints through the use of case studies.¹⁹¹

189. Defence told us ‘SeMPRO incident management and response workshop products are subject to continuous content review based on the feedback of participants and presenters’.¹⁹² However, formal evaluation is yet to occur:

In 2021–22, there was a first attempt at evaluation of the SeMPRO incident response workshops. The process called for volunteers to be interviewed about the workshop two to three months after workshop completion. The results of the evaluation had limited utility as the uptake was limited to those who were enthusiastic about the workshop, which skewed the results. Until 2023, the research arm of SeMPRO was under-resourced to start an evaluation activity. The growth of the Research and Evaluation capability to three staff and the development of the SeMPRO Evaluation Program is intended to improve SeMPRO evaluation efforts.¹⁹³

190. When she gave evidence in March 2024, Ms Urquhart confirmed the workshops had not yet been formally evaluated. Ms Urquhart did not believe there was a correlation between the higher number of SeMPRO advice clients and the low attendance rates at the workshops for commanders and managers.¹⁹⁴

191. In the absence of any formal evaluation of the workshops, we are unable to draw any firm conclusions as to why SeMPRO has a large proportion of clients seeking advice on how to manage a sexual misconduct incident. It may be due to a lack of knowledge, a need for additional tailored support, or a combination of both. Regardless, it is clear that commanders and managers must receive adequate training to manage sexual misconduct incidents when they do occur, and that the current workshop must be evaluated to ensure it is effective.

Workshop must be evaluated, improved and then be mandatory

192. We accept ADF managers and commanders have a significant training load. However, capability gaps must be addressed, particularly where they affect members' safety and wellbeing. Managing sexual misconduct incidents must be a high priority for mandatory training, for the current and next generation of leaders.
193. The Defence Abuse Response Taskforce (DART) highlighted the capability gap for leaders in managing unacceptable behaviour incidents, including sexual misconduct. It found a significant proportion of incidents between 2000–2011 were mismanaged. The Taskforce made 1,723 reparation payments, of which '97% included a payment for Defence mismanagement'.¹⁹⁵ The Taskforce noted the 'very significant impact' of mismanagement on victims.¹⁹⁶
194. However, before the ADF makes the Sexual Misconduct Incident Management Workshop mandatory, it must be confident the workshop delivers what is intended.
195. Defence considers a participant is proficient on the basis of attending the workshop, rather than any form of assessment:

Defence uses the term proficiency to indicate attendance on a training activity. As all incidents of sexual misconduct, including sexual offences, are different, responders are required to apply a flexible, trauma-informed approach that is unique to each situation. On this basis, measurable competency-based assessments are not reflective of the learning.¹⁹⁷

196. We accept each incident requires a tailored approach, depending on the individual circumstances. However, the workshop's purpose is to ensure commanders and managers are able to apply the relevant policies and trauma-informed principles to individual circumstances. There is no reason why participants' understanding of the workshop content cannot be evaluated.

197. Ms Urquhart confirmed Defence will evaluate the Application of Knowledge modules under the Kirkpatrick model (an internationally accepted approach to assessing training outcomes), in line with the Systems Approach to Defence Learning:

Within the SADL [Systems Approach to Defence Learning], levels 1 and 2 [of] the Kirkpatrick model are referred to as Learning Review (Implement Phase) and levels 3 and 4 are referred to as Evaluation (Evaluate Phase). The Kirkpatrick model levels measure the following areas:

Level 1 – the effectiveness of the learning administration

Level 2 – the degree to which learners acquire the knowledge, skills, attitudes and behaviours from a learning event

Level 3 – the application of the learning in the workplace

Level 4 – the strategic organisational results.¹⁹⁸

198. As a matter of priority, an independent external evaluator must assess the Sexual Misconduct Incident Management workshop using the same approach. Required improvements should be made to the workshop before making it mandatory for all current commanders and managers, as well as those in training.

Recommendation 16: Evaluate training on managing sexual misconduct and make it mandatory for all leaders

Defence should commission an independent evaluation of the Sexual Misconduct Incident Management Workshop as a matter of priority. Following any required improvements identified by this evaluation, sexual misconduct incident management training should be mandatory for all commanders and managers.

8.4.3 Preventing sexual misconduct

199. The Australian Human Rights Commission (AHRC) Respect@Work report recognises the norms and practices that lead to violence ‘are not innate elements of human behaviour, nor are they fixed practices of society. Sexual harassment, like other forms of violence against women, is preventable’.¹⁹⁹ In Chapter 7, Culture and leadership, we discuss the underlying causes of all forms of unacceptable behaviour, including sexual misconduct, and make our recommendation to ensure the Defence Respect@Work Framework leads to meaningful change. Here, we focus specifically on sexual misconduct.

200. There are three levels of prevention:

- Primary prevention relates to ‘violence prevention initiatives that take place before violence has occurred’ and are typically targeted at a population-wide level.
- Secondary prevention, or ‘early intervention’, ‘aims to stop early signs of violence among people at higher risk of experiencing or perpetrating violence’.
- Tertiary prevention refers to responses to violence after they have occurred, often called ‘behaviour change’ programs in the context of sexual violence, and aims to ‘stop the recurrence of violence’.²⁰⁰

201. The Respect@Work reforms seek to ‘shift ... the system to focus more on preventative efforts to eliminate sexual harassment in Australian workplaces’.²⁰¹ From December 2023, the *Anti-Discrimination and Human Rights Legislation Amendment (Respect at Work) Act 2022* (Cth) came into effect:

The Act introduces a new **positive duty** on employers and persons conducting a business to take *reasonable and proportionate* measures to eliminate, as far as possible, certain discriminatory conduct, including sex discrimination, sexual harassment, sex-based harassment and certain acts of victimisation in the workplace context.²⁰²

Primary prevention and early intervention are limited

202. The AHRC recognised:

Primary prevention is critical because, of the three levels of prevention, it is recognised as having the potential to make the largest impact on reducing violence against women, whereas ‘[t]ertiary and secondary prevention, while essential, are unlikely to significantly reduce the rates of violence against women on their own’.²⁰³

203. Group Captain James confirmed SeMPRO’s education programs are the only enterprise-wide programs directed at the prevention of sexual misconduct.²⁰⁴ They were only made mandatory in 2023 and, as noted, are yet to be evaluated for effectiveness. Defence also told us ‘education is a necessary contributor to behavioural and culture change programs, but in isolation, it is not sufficient as a tool to effectively prevent sexual misconduct’.²⁰⁵ We agree.

204. The US Independent Review Commission on Sexual Assault in the Military provided a range of examples of prevention and early intervention initiatives, including:

- ‘hot spot mapping’, where unsafe areas are identified and updated (such as through better lighting, surveillance or security)
- infrastructure changes or removal, particularly for old, dilapidated or insecure housing and barracks

- training local staff (such as local restaurant and bar staff) to identify and intervene in cases of sexual misconduct
- targeting and identifying locations and occupations where harmful social norms may be able to flourish – for example, bases or occupations where there is a significant lack of gender diversity
- restricting members' movements in high-risk areas and promoting their movement in safer, more protective spaces
- policies that carefully manage the use and availability of alcohol
- working closely with community services, including police and women's shelters, to understand local community risks and protective factors
- providing members with healthy ways 'to blow off steam', including hobbies and fitness activities that do not involve alcohol.²⁰⁶

205. The ADF has taken some initial steps to improving prevention and early intervention at particular locations, which incorporate some of these actions. SeMPRO is undertaking a Sexual Misconduct Risk Assessment Trial that will use:

site-specific assessments to design actions, interventions, and changes to prevent sexual misconduct ... the trial will use the knowledge of personnel in location to understand the unique risks, protective factors and opportunities for change that could reduce the potential for sexual misconduct taking place using the socio-ecological model of crime prevention.²⁰⁷

206. The trial includes interviewing 'subject matter experts' at each site, conducting focus groups with members who work and live on-base, and a physical walk around the base to identify specific protective and risk factors. It then recommends improvement to the leadership team, which SeMPRO will help implement.²⁰⁸

207. At the time of writing, SeMPRO had visited three locations, providing two with recommendations. A fourth site visit was yet to occur.²⁰⁹ Recommendations so far include changes to bathroom facilities, to increase privacy and segregation, and the promotion of on-site social facilities that do not involve the consumption of alcohol.²¹⁰ Although this is a promising step, it remains a small-scale intervention compared to the enterprise-wide challenges facing the ADF.

208. Then Sex Discrimination Commissioner Ms Kate Jenkins told us many institutions have failed to prioritise prevention activities:

we identified that in the past a lot of organisations have really focused on complaints and responding to sexual harassment rather than taking genuine steps to prevent the sexual harassment before it occurred. So we made recommendations that really shifted organisational focus to take more of a prevention approach, particularly learning from safety laws that have really improved practices over time. You don't wait until someone is injured to fix it, you actually take steps to prevent the injury.²¹¹

209. The US Independent Review Commission on Sexual Assault in the Military made a similar point:

As one SARC [Sexual Assault Response Coordinator] emphasized, ‘Educating the community on available resources does not equal prevention. Giving someone a water bottle with the hotline number is too late—that’s response, not prevention. They tend to get conflated.’²¹²

210. When we asked Defence to identify prevention initiatives, two out of the four it listed were response actions: SeMPRO’s Client Response team and the ‘interactive framework’ to accompany CARM Chapter 9, ‘Responding to Sexual Misconduct’.²¹³

211. SeMPRO’s Group Captain James agreed Chapter 9 focuses on responding to sexual misconduct after it has occurred, and the majority of people contact SeMPRO after sexual misconduct has occurred. However, she still believed it accurate to describe the client response team and CARM Chapter 9 as prevention activities:

Yes, it is. They do still form a preventative activity as well. So their primary responsibility, yes, is response, it does fall within the response aspect of prevention and response, but we can’t discount the value that they add with what we call, like, a soft education approach.²¹⁴

212. We do not consider the current approach to prevention and early intervention in the ADF is adequate. We consider responding to sexual misconduct has been conflated with preventing it. General education programs were only made mandatory in 2023, and have not been evaluated. While small-scale efforts are underway to improve prevention and risk-identification at specific sites, a systems-level approach is needed.

No prevention programs targeting perpetrators

213. The IGADF Inquiry found the ‘understanding of perpetrators of sexual misconduct in the ADF is limited and consequently behaviour change programs cannot be appropriately developed and targeted for perpetrators’.²¹⁵ The Inquiry recommendations included:

Recommendation 6. Sexual misconduct management must provide for a greater focus on perpetrators and prevention. Defence data and research capability is well able to assist with this task.

Recommendation 7. Prevention should include a focus on behaviour change programs which are appropriately developed and targeted for perpetrators and based on Defence research.²¹⁶

214. Defence told us it has ‘decided to implement the recommendations in a modified form’:

Recommendations 6 and 7 will be combined – Sexual misconduct management in Defence provide for a greater focus on developing targeted prevention and behaviour change programs.

These recommendations seek to address prevention (i.e. take action before perpetration) and the perpetrator. Both recommendations relate to focusing Defence action on programs to enhance understanding and action on prevention and perpetrators. Consolidation into a single implementation task avoids duplication and confusion.²¹⁷

215. Defence confirmed it has not commissioned research in response to the IGADF Inquiry.²¹⁸ However, it noted research was already underway on topics including 'new relationship definitions; technology facilitated sexual violence; sexual offence misconceptions; temporal aspects of sexual offending; and recidivist offenders'. In July 2023 Defence told us this recommendation was due to be implemented by Q2, 2024.²¹⁹

216. Asked for information on programs targeted at perpetrators or potential perpetrators, Defence told us:

Defence does not provide and is not developing programs specifically targeted at perpetrators or potential perpetrators of sexual misconduct, (i.e. individuals who have had an incident of sexual misconduct substantiated against them or who were involved in an investigation involving such conduct against them).

In the event of alleged or substantiated sexual misconduct individuals are referred back to the Foundation of Knowledge training.²²⁰

217. In the same response, Defence stated that the Foundation of Knowledge course 'is not specifically aimed at perpetrators'. We note this course was mandatory from January 2023.²²¹ It is unclear what would be gained from perpetrators retaking a course when it hasn't had the desired effect the first time.

218. During our procedural fairness process, Defence said it 'remains focused on developing targeted prevention and behaviour change programs and further action is planned following completion and analysis of research'.²²²

219. It is challenging to reconcile Defence's two responses and determine what precisely Defence is planning to develop in terms of behaviour change programs, which by definition are targeted at perpetrators. Ongoing scrutiny is required to ensure the intent of this recommendation is achieved.

220. Group Captain James told us her views on behaviour change for sexual offenders:

I believe that people's behaviours can be corrected and when we're discussing sexual offences and convictions for sexual offences, we are including behaviours of a non-penetrative nature. An example may be that someone is, you know, touched on the private regions or given a kiss on the cheek that is unwanted and unwelcome and that can constitute a sexual offence. So that sort of behaviour can be corrected. Defence does take those behaviours seriously and your punishments can include time in our own corrections facility. So we do take those behaviours seriously.

Is it an offence that should require that member to be separated from the Defence Force? I don't believe so if it can be corrected, but an offence of a more extreme nature, then a punishment that includes dismissal from the Defence Force is appropriate.²²³

221. We note a significant number of victims have told us about the harmful and long-lasting impacts of non-penetrative sexual offences. Academics and other Five Eyes nations include these types of offences in the definition of military sexual trauma or violence. The seriousness of this behaviour should not be underestimated, nor should the significant physical and psychological consequences for victims.

222. When asked how the ADF corrects sexual offending behaviour, Group Captain James stated:

An example would be whilst a member spends time in the Defence Force correctional facility, there is a re-education program that is tailored to the offence that they have been convicted of, so there is a responsibility there. And, again, coming back to that command responsibility to ensure that people behave as expected of them in the Defence Force, so command would take on the responsibility for that corrective action.²²⁴

223. Defence provided the following information on the re-education program, and confirmed there is no training package specifically aimed at perpetrators of sexual offences:

The DFCE [Defence Force Corrective Establishment] Training Program was redeveloped in 2022 but maintains focus on the basic character traits associated with Service life:

- Positive attitude – towards the Service, superiors, peers and employment
- Conduct and bearing – consistent with good order and military discipline
- Efficiency – achieving results by making the best use of resources
- Dress and personal cleanliness – present well and maintain personal appearance
- Self-confidence – in their relationship with their superiors, peers and subordinates
- Self-esteem – improved self-worth
- Time management – achieve results in a timely manner; and
- Reliability – ability to carry out duties with minimal supervision.

A detainee's day will consist of a range of activities and tasks drawn from broad groupings across four pillars: ethics, wellness, learning and discipline. All activities and tasks aim to build upon and promote the Defence values.

DFCE is staffed by service personnel drawn from a range of employment categories, who will develop a corrective training program particular to the detainee, delivering core lessons and knowledge coupled with Service or employment specific components ...

DFCE does not currently provide any set training package that is specifically focused towards the rehabilitation of sex offenders.²²⁵

224. Given the specific nature of sexual offending, it is difficult to see how such a generalised program could address any of the underlying issues that lead to sexual offences being committed. As Defence has stated, there is no training package focused on rehabilitating perpetrators of sexual offences who are in detention; the current approach is insufficient. We note it relies on a sexual offence perpetrator being put in detention following a conviction. However, since January 2018, only six members convicted of sexual offences have been detained as part of their punishment, at least one of which was a suspended sentence (see section 8.5.3 for details).²²⁶

ADF lacks a comprehensive strategy to prevent sexual misconduct

225. Sexual misconduct remains a systemic issue in the ADF, and a much more comprehensive approach to prevention is needed. US Independent Review Commission on Sexual Assault in the Military recommendations provide a useful starting point:
- Equipping leaders with the appropriate skillset to understand and oversee prevention activities among their teams. Leaders should then be held accountable for failing to take appropriate action to prevent, in this case sexual violence, before it occurs.²²⁷
 - Developing a 'state-of-the-art DoD [Department of Defense] prevention research capability'. This will improve institutional understanding about military violence and support it in making data and research-informed decisions about how best to target that violence, and develop, implement and evaluate primary prevention.²²⁸
 - Implementing prevention strategies at both the individual and the organisational or community levels. This is because different military environments demand different approaches to prevention, due to significant differences in the contextual risk and protective factors.²²⁹
226. The Independent Review Commission also recommended establishing and appropriately funding 'a dedicated primary prevention workforce'. Its report said, 'effective prevention ... requires the time and dedication of full-time personnel with specific public health and behavioural social science expertise'.²³⁰ It found this requires:
- separate education and training apart from response and cannot be retrofitted or repurposed from a victim response workforce. Doing so would not only be a disservice to victims, whose care and support should be the sole focus of response personnel, but also fundamentally will not move the needle on prevention.²³¹

227. The Defence Respect@Work Framework also provides a strong starting point, as it identifies risk and protective factors for all forms of unacceptable behaviour in the ADF. However, the dynamics of sexual misconduct, particularly the gendered patterns of male violence against women, require a dedicated approach. It is one that includes primary prevention and early intervention, as well as targeted behaviour change programs for perpetrators of sexual misconduct. Even if the Australian Government accepts our recommendation that there should be a presumption of discharge for perpetrators of certain forms of sexual misconduct (discussed in section 8.7), in the event a member is retained, it is critical they undergo evidence-based behaviour change programs to ensure the incident is not repeated.
228. Defence is developing a sexual misconduct prevention and response strategy, which was still in draft at the time of writing. The draft strategy acknowledges there are areas where Defence 'can do better', and is described as a 'call to action'.²³² We acknowledge the strategy is a work in progress and draw no conclusions. However, the draft strategy provided to this Royal Commission contained no actions or timeframes, and was largely a summary of existing Defence policies and frameworks, including the Defence Respect@Work Framework. It applied at the enterprise-level, and was not tailored to the ADF context. In its current form, it is grossly insufficient to achieve the intended outcome of our recommendation.
229. The ADF must develop a tailored, comprehensive strategy to preventing sexual misconduct, which will require specialist, external expertise. Defence has told us SeMPRO does not conduct research to understand why sexual misconduct occurs, as this is considered to be outside its remit.²³³ The strategy should be developed in partnership with the Australian Human Rights Commission and Our Watch, as the national leader in primary prevention research, training and development for preventing and addressing violence against women.²³⁴
230. The strategy should include specific implementation actions, including timeframes, and be tailored to the ADF. It should be submitted to the Minister for Defence and the Minister for Defence Personnel for endorsement, and published on the Defence website. It is essential the ADF is held to account for preventing sexual misconduct in the workplace given the impact on individual victims and the broader negative consequences for military capability.

Recommendation 17: Prioritise the prevention of sexual misconduct in the Australian Defence Force

The Australian Defence Force should develop a comprehensive sexual misconduct prevention strategy that includes primary prevention and early intervention, as well as targeted behaviour change programs for perpetrators of sexual misconduct.

The strategy should be:

- (a) developed in partnership with the Australian Human Rights Commission and Our Watch, include specific actions for implementation, including timeframes, and be tailored to the ADF context
- (b) submitted to the Minister for Defence and the Minister for Defence Personnel for endorsement, and published on the Defence website.

8.4.4 Few workplace protections for victims

231. When policies preventing sexual misconduct fail, there must be appropriate protections for victims. Our inquiry found this was also left largely to the commanding officers who have responsibility for managing complaints. However, the ADF provides little training or guidance on how its leaders are to do this.

Lack of guidance while investigations are underway

232. There is a lack of detailed policy guidance for commanding officers about ensuring victim safety during sexual misconduct investigations. Chapter 3 of the Complaints and Resolutions Manual (CARM) provides the following guidance:

Managing workplace relationships

If an incident of unacceptable behaviour gives rise to issues that negatively affect the working relationships between two or more people, commanders and managers are to take action to restore that relationship, where appropriate. This is in addition to dealing with the unacceptable behaviour.

Note: Discretion is to be used based on the type of unacceptable behaviour that has allegedly occurred, for example sexual offences or violent behaviour.²³⁵

233. Defence also provided the following information, which demonstrates that decisions rest with commanding officers:

Commanders and Managers have an obligation, under WHS provisions to ensure a safe working environment for all staff, including in an instance where sexual misconduct is being investigated. During this period the Commander or Manager can implement a range of approaches to ensure the safety and wellbeing of the impacted person including modifying shift patterns, relocating either the respondent or the complainant to another work area, or facilitating a working from home arrangement (where operationally suitable).

One support option available, as outlined in in Complaints and Alternative Resolution Manual (CARM) Chapter 3 Annex J, to ADF commanders is a temporary transfer. This option is available at the commander's discretion and applies to both a complainant and a respondent.

Additionally, there are a number of actions a Commander or manager may take whilst a matter of sexual misconduct is under investigation, whilst criminal or disciplinary proceedings are pending, or after those proceedings have concluded, such as imposing administrative sanctions on the alleged perpetrator/respondent (i.e. counselling, formal warning, censure, reduction in rank, or termination). Disciplinary action under the *Defence Force Disciplinary Act 1982* may also be considered.²³⁶

234. The IGADF Inquiry highlighted the difficulties commanding officers face when trying to afford members procedural fairness and also keep the victim safe while an investigation is ongoing:

In addition to suspension from duty, COs [commanding officers] have a range of options they can take to manage a situation before any formal investigation or outcome is completed. This ranges from posting one of the parties away from the unit, instituting freedom of movement restrictions or adjusting working hours. Balancing the rights of both the victim and respondent in this situation can be challenging.

As one CO put it: Being victim-centric, it's don't forget about the victim. But the respondent. It's a concern particularly in a small unit, how do you look after the respondent. People can see what's happening. Protecting both people is a tough one. My initial thought is [to move] the respondent but it is hard to know until you know what happened, the victim has to be supported. But then people go 'ah, they must have done it, they've been moved!' That's the difficult situation all commanders are put in. You have to do something. You have to manage the appearance of whatever decision you've made. It's easy to protect the victim but you have to look after the respondent too.

Another put it more succinctly 'How do you not disadvantage either member?'²³⁷

235. Commanding officers also provided feedback on the case studies in CARM during the IGADF Inquiry and said they could be improved:

More often, commanding officers said they would find it useful to have access to detailed case studies to which they could refer for greater guidance. Case studies should be presented at every opportunity in training, updated and promulgated to the ADF audience, and incorporated in extant policy. While Chapter 9 of CARM currently contains some short case studies, they are overly simplistic. As one CO commented, 'I've never had an incident as clear as say someone standing over the bloodied body with 20 people who saw you stab him. It's always been much more opaque'. The present rewriting of Chapter 9 is an opportunity to ensure it gives clear and consistent guidance, with detailed and relevant case studies drawn from ADF experience.²³⁸

236. CARM Chapter 9 was updated in 2022 and no longer contains case studies. It now says:

Commanders and managers are to respond promptly to all reported sexual misconduct incidents. The primary role of commanders and managers in managing incidents of sexual misconduct is to ensure the safety of Defence personnel, promote their wellbeing, and facilitate access to appropriate services. Commanders and managers are also required to ensure the welfare of respondents and other witnesses under their command. A fact sheet summary for commanders and managers on how to meet this chapter's policy guidance is available on the SeMPRO intranet page.²³⁹

...

Sexual harassment and sex discrimination incidents can give rise to issues that negatively affect the working relationships between those involved and within the team more generally. Commanders and managers should ensure that personnel in their chain of command or line management are aware of the support options available to them. Those options include services such as those provided by SeMPRO client services, chaplains, MHPS [Mental Health and Psychology Service] and external providers.²⁴⁰

237. A fact finder – that is, an officer responsible for collecting information to support decision-making after an incident has been reported – noted the lack of clear policy guidance when investigating a complaint about how the Air Force handled a reported sexual offence. The group captain overseeing the fact finding agreed, stating that:

The Fact Finder noted, and I agree, that relevant ADF and single service policies tend to focus on who or which unit is responsible for timely incident reporting and recording, providing far less guidance on the more complicated issue of managing complainants and respondents in the short and long term. There is a constant tension between managing a respondent's presumption of innocence and being victim-centric, and every case will be different and require different management actions. Nonetheless, the Fact Finder identified a number of policy changes that may assist with management of similarly complicated situations in future, with a view to achieving a more victim-centric approach and outcome ...

The five recommendations supporting proposed policy changes are identified below.

Recommendation 1. Commanders reconsider management of an accused respondent once civilian charges laid. Policy changes under this recommendation should specifically identify/call out the requirement for Commanders to reconsider whether to suspend, post or otherwise move the accused once civilian charges are laid.

Recommendation 2. Commanders and Command Legal Officers should refrain from considering the strengths or merits of the prosecution case as a basis for any administrative decision making.

Recommendation 3. The language should change from 'respondent' to 'accused' and reference the actual charge as opposed to using the term 'sexual misconduct'. Policy changes under this recommendation should clearly identify a requirement for language used in incident reporting/recording and decision-making reasons to change from 'respondent' to 'accused' once charges have been laid, and the actual charge should be used (ie: 'rape', not 'sexual misconduct').

Recommendation 4. Policy guidance as to how long a member should be suspended. Policy changes proposed under this recommendation should identify factors for COs to consider, particularly guidance on the length of suspension for accused members facing lengthy court proceedings.

Recommendation 6 [sic]. That policy set out the special management considerations for the following situations:

- When the complainant and respondent are from different units
- When the complainant and respondent are in regional locations/deployed
- When the complainant and respondent live on base
- When the complainant and respondent are in a training establishment.

I agree with these recommendations from the Fact Finder. These outcomes will be shared with appropriate elements of Air Force Headquarters, to enable their consideration for amendment/improvement of Air Force and wider Defence policy. Additionally, there are currently a number of reforms occurring to ADF policy on the management of sexual misconduct. AFHQ [Air Force Headquarters] will ensure the recommendations arising from your complaint are considered by these reform programs, notably the rewrite of Chapter 9 of the Complaints and Alternative Resolutions Manual and an own-motion inquiry recently commenced by the IGADF into ADF handling of sexual misconduct.²⁴¹

238. As noted above, the level of guidance recommended in this report is not reflected in the updated version of Chapter 9 of CARM, and no additional detail is provided in the accompanying 'interactive framework'.²⁴²

Commanding officers need clear policy guidance

239. Commanding officers must balance multiple considerations while a sexual misconduct investigation is underway. In particular, they need to ensure victim safety and manage any broader safety risks to the unit (particularly in light of the new positive duty to prevent sexual harassment), and preserve procedural fairness for the alleged offender. Currently, the risks associated with these decisions rest with individual commanding officers, who may lack the training and skills, and which can lead to an overly conservative and inconsistent approach organisation-wide.

240. While not specific to incidences of sexual misconduct, Defence provides some guidance on suspending members from duty during administrative, disciplinary or criminal proceedings. The Military Personnel Manual (MILPERSMAN) emphasises that suspension from duty is not punitive, and should only be used if alternative measures would be ineffective:

Suspension from duty is not a punishment or sanction for misconduct. While its effect on a Defence member may be detrimental, the reasons for suspension should be protective – for example to protect a member's safety, the integrity of an investigation, or Defence's reputation. A Defence member should only be suspended when other measures, such as temporary or permanent re-assignment of duties, are not sufficient to meet the relevant protective purpose.²⁴³

241. In the Army, the Chief of Army Directive, Management of Army Members Involved in Administrative, Disciplinary or Criminal Processes, provides that:

Where administrative, disciplinary or criminal processes are occurring, COs remain responsible for the effective functioning and security of the capabilities under their command as well as the safety, security, welfare and morale of members involved. In order to achieve this, COs are to ... [c]onsider what interim action or arrangements may be required in order to ensure a safe and supportive workplace, protect unit security and effectiveness, protect morale, protect information, assets and people, and protect the reputation of the Army.

COs are to carefully consider whether interim actions should be taken, ensuring that they are only for protective purposes and are not to be punitive in nature. Interim actions may include:

- restricting access to and/or use of weapons, ammunition, explosive ordnance or classified material
- restricting access and/or use to Defence vehicles
- ordering targeted testing for alcohol misuse or prohibited substance misuse
- referring affected members for psychological screening and evaluation (via PM008) [referral for a mental health /psychological assessment and management advice] to inform further decision-making
- ordering affected members not to interact with specific individuals
- flexible work arrangements
- internal or external to unit reassignment of affected members
- temporary removal from command, instructional or representational appointments and employed in other duties
- suspending members under the command power as a last resort.

... Any action taken should be reviewed on a regular basis, but no less than monthly. Should the action no longer be required, the member is to be restored to full duty and/or ordinary working arrangements without delay.

... Decisions to suspend must be made based on the particular facts of a situation; it does not imply that a member has undertaken the alleged conduct, nor is it to be punitive in nature. While the effects of suspension on an Army member may be detrimental, the reasons for suspension must be protective.²⁴⁴

242. The Directive also provides that 'COs are to ensure that the potential stress and anxiety suffered by individuals is reduced so far as reasonably practicable'. Support Officers must be appointed for victims and alleged perpetrators, and COs must ensure members have access to a range of support mechanisms including medical, psychological, welfare, chaplains and legal.²⁴⁵ As noted in Chapter 10, The ADF military justice system, further work is needed to ensure the support offered by the ADF is effective (noting this applies to all types of administrative and disciplinary proceedings, not just sexual misconduct).
243. The legislative and regulatory criteria governing when a member can be suspended from duty with or without pay are set out in Annexure 8.2. In addition, the command power can be used to suspend members from duty with pay if these criteria are not met (for example, if the form of sexual misconduct does not constitute an offence).²⁴⁶
244. We examined the policies that apply in other public service organisations to managing victim safety and ensuring procedural fairness while sexual misconduct investigations are underway. These are also set out in Annexure 8.2. We particularly noted the Victorian Police approach, which was developed following an independent review by the Victorian Equal Opportunity and Human Rights Commission of sexual harassment in the Victorian Police Force.
245. If a Victorian Police employee is subject to a sexual misconduct report, one of the following interim actions must be taken:
- the employee is directed to take leave
 - the employee is transferred to another work location or alternative duties
 - the employee is suspended (with or without pay).
246. Decision-makers must consider a range of factors when taking interim action, including the seriousness of the allegations, the risk to the victim and alleged perpetrator, and the broader workplace.²⁴⁷
247. The ADF needs a clear organisational policy to guide commanding officers and ensure appropriate action is taken following a report of any form of sexual misconduct.
248. A similar policy should be adopted to that of Victoria Police, which would require a commanding officer to take immediate interim action following a report of sexual misconduct, informed by a comprehensive risk assessment. None of the recommended actions imply guilt, but are intended to keep all parties safe while an investigation is underway. This approach would ensure the action is tailored to the circumstances, and unlike the current policy approach, it explicitly requires a risk assessment and some form of action to occur.

249. Commanders must be supported to examine the safety, health and wellbeing risks following a report of sexual misconduct, and take appropriate action without worrying this may be perceived as affecting procedural fairness.
250. Noting the unique circumstances of the ADF, some important distinctions should be made:
- Suspension without pay should not be a potential immediate interim action given the legislative and regulatory constraints that apply.
 - However, in the event an alleged perpetrator is charged with an offence, the policy should not preclude suspension without pay, consistent with the *Defence Force Discipline Act 1982* (Cth).²⁴⁸
251. As discussed in Chapter 10, The ADF military justice system, we note the ADF is developing a tri-service directive to ensure consistency in administrative and disciplinary investigations. However, given the particular risks to safety, health and wellbeing associated with all forms of sexual misconduct, including the risk of suicide and suicidality, we consider a specific policy should apply to sexual misconduct incidents. The ADF is best placed to determine whether this should be a stand-alone policy or a dedicated section within the broader tri-service directive.

Recommendation 18: Strengthen workplace protections during sexual misconduct investigations

The Australian Defence Force should develop a dedicated policy that applies when sexual misconduct incident investigations are underway in the administrative, disciplinary or civilian justice systems.

The policy should:

- (a) provide that the commanding officer must immediately apply one of the following interim actions to the alleged perpetrator, neither of which imply any finding of guilt or wrongdoing:
 - (i) amend their work arrangements to ensure no contact between the victim and the alleged perpetrator (depending on the nature of the work, this may require re-assignment to a different location), noting that the arrangement must not restrict the victim from accessing any common areas
 - (ii) allow suspension with pay
- (b) ensure that the commanding officer's decision must be informed by a comprehensive risk assessment of the safety, health and wellbeing of the victim, the alleged perpetrator and the broader workplace, with the reasons for the decision being recorded
- (c) ensure that interim actions are reviewed on a regular basis until the matter has been resolved through both the disciplinary (or criminal) and administrative systems.

The policy should not preclude the commanding officer from:

- (d) suspending an alleged perpetrator without pay (either in full or part), in accordance with the *Defence Force Discipline Act 1982* (Cth) and the Defence Force Regulation 2016
- (e) taking any additional interim actions as necessary.

Victims may be ostracised and subject to ongoing abuse

252. The DART final report noted 'abuse was often exacerbated and the complainant victimised after it became known that the complainant had reported the sexual harassment'.²⁴⁹ Sadly, we have heard lived experience evidence of similar experiences.

253. Reverend Dr Nikki Coleman described her experience of being ostracised in the Air Force after making a formal complaint in 2020 about multiple sexual misconduct and unacceptable behaviour incidents, all of which were substantiated.²⁵⁰ In Reverend Dr Coleman's words:

... I was just cast aside. I was uninvited from chaplaincy events that I would normally be attending so that my abuser could attend. I was ostracised. I had falsehoods spread about me by a senior chaplain. It was unlike any other workplace I've ever been in. It was horrendous and I'm exceedingly grateful for the pastoral care provided by the Army chaplaincy branch or I don't think I'd be alive.²⁵¹

254. Reverend Dr Coleman also described how the Air Force confined her to work in one building while the perpetrator was given much more freedom:

So I was limited to R1 and my abuser was allowed to go into every other building, R2 to 8. Except on a Monday, I think. I was to work elsewhere so that my abuser could meet with both of our COs. I actually happened to work on the same floor as my CO, our shared CO, so that he could have those regular weekly meetings that are normal for that position, but I was to work elsewhere. But the rest of the time, I was confined to R1 and my abuser was working between R2 and ... able to go into buildings R2 to R8.

...

... the co-workers in my team, in the Space Domain Review team, one day invited me to go and have lunch with them in the R2 cafe and I had to tell them that I wasn't allowed in that building, which I found really humiliating. I couldn't tell them why because I'd been told to not disclose the outcomes of the unacceptable behaviour. So it was quite difficult for me.²⁵²

255. We also heard evidence from BR1, for whom SeMPRO arranged an emergency posting after she was sexually assaulted. She was still subject to comments that it would end her career because she was 'creating paperwork', and that she had 'brought this on [her]self'.²⁵³

Policies to support victims return to work are inadequate

256. Defence has advised there is no specific policy to support victims of sexual misconduct to return to work following the incident. It said the same supports are available as for all victims of unacceptable behaviour:

The CARM Chapter 3 (which also applies to sexual misconduct) covers support options for complainants, and the Guidance for Commanders, Managers and Supervisors Factsheet covers the steps to handle a complaint of unacceptable behaviour, which includes where unacceptable behaviour has been substantiated.

Commanders and Managers can contact 1800 SeMPRO for advice and support in managing the wellbeing of a complainant, using a trauma-informed approach.

...

Additionally, the trauma-informed approach is a key component of the interactive SeMPRO Sexual Misconduct Incident Management Workshop. This workshop is informed by Chapter 9 of the Complaints and Alternative Resolutions Manual, and outlines the processes required for managing incidents of sexual misconduct and guides participants through using strategies that promote capability and wellbeing.²⁵⁴

257. As noted in section 8.4.2, the incredibly low attendance rates at Sexual Misconduct Incident Management Workshops give us no confidence this is an effective tool.
258. CARM Chapter 9 does not have a dedicated section on supporting victims of sexual misconduct to return to work. It just has broad statements about the importance of victim wellbeing and a trauma-informed approach, and the role of SeMPRO in supporting commanders and managers. We therefore do not consider CARM provides robust, practical guidance about how to ensure a victim of sexual misconduct is provided a safe working environment, grounded in clear decision-making principles.
259. Reverend Dr Coleman requested SeMPRO's involvement in her reintegration into the chaplaincy branch. She was told there are no policies or processes in place to support this:

Even though I had been ostracised by the branch, I genuinely care about my work colleagues and I love my job and I wanted to go back into working as a chaplain. SeMPRO, unfortunately, don't have policies and processes in how to reintegrate a sexual harassment and a sexual assault complainant back into the workforce, which really surprised me because, whether by accident or design, they appear to have been set up to fail because they don't have those processes to enable victims to go back to work. It seems that it's built into the system that victims are expected to just quietly leave rather than reintegrate back into teams. I think that significant oversight is a huge problem for SeMPRO's capability of what they do.²⁵⁵

260. When Counsel Assisting asked Reverend Dr Coleman whether the lack of policy or processes came up during her discussions with SeMPRO, she responded 'Yes. They suggested I write it'.²⁵⁶ Giving evidence in Hearing Block 12 in March 2024, Group Captain Fleur James, Head of SeMPRO, confirmed nothing had been done to create a policy following Reverend Dr Coleman's evidence in August 2023.²⁵⁷
261. Following Hearing Block 12, the Commonwealth agreed that Defence policies and processes to support victims of sexual misconduct returning to the workplace are inadequate. Defence acknowledged that 'more can be done to support victims of sexual misconduct returning to the workplace', and provided the following information on work underway:

Defence is drafting a section of CARM 9 detailing person-centric considerations to support victims of sexual misconduct returning to the workplace. This will ensure commanders and managers can readily locate information on their responsibilities, identify resources to assist them through the process, and provide an aide-mémoire to assist in their decision-making and support to victims.²⁵⁸

262. This is a positive development, albeit well overdue.

Systemic issues damage victims' careers and jeopardise their safety

263. Victims of sexual misconduct must not be punished or disadvantaged in any way, directly or indirectly. CARM Chapter 9 states:

The complainant should not be directly disadvantaged or punished because they reported a sexual misconduct incident to Defence. Decisions intended to keep members safe can bring unintended disadvantages or consequences. Speaking with, and advising, the complainant before taking action in areas such as postings, courses, accommodation and deployments applies a trauma-informed approach.²⁵⁹

264. However, Defence policies make it difficult to achieve this in practice.

265. Defence provided the following non-exhaustive list of options available to manage interactions between victims and perpetrators of sexual misconduct:

- Navy: an 'out of cycle' or short-notice posting at the commanding officer's request; a temporary (up to 90 days), locally approved move as an immediate response, after which the member is posted or returned to their original unit²⁶⁰
- Army: relocating personnel, changing working hours or shifts, flexible working arrangements or an alternative posting. Interim considerations may extend to half-days and allow for attending appointments²⁶¹
- Air Force: changes to work routines or arrangements, a temporary movement to another workplace, or engagement with the Career Management Agency to request a formal posting of one of the members.²⁶²

266. However, Defence acknowledged that pursuing these options can have negative consequences on a victim's career, stating that 'posting action at short notice will generally not be consistent with the career advancement needs of the member'.²⁶³ For example, in the Navy, out of cycle or short notice posting action may be warranted:

- when there are disciplinary or administrative concerns
- to enable the compulsory cancellation of a force assignment
- when circumstances 'degrade the member's work performance, so that there is an unacceptable safety risk or degradation in capability ... irrespective of the member's preference'
- in exceptional circumstances, where a member's performance is below standard and retaining them 'prejudices the ability of the unit to complete operational tasking, or an unacceptable risk to safety arises that cannot be mitigated'.²⁶⁴

267. All of these circumstances have negative connotations and reinforce why short-notice postings generally carry a career penalty. In other cases, what may be considered supportive can have unintended career consequences when a member's ability to deploy is withdrawn:

Should the member need reduced or specific working hours for more than 28 days, the member's Medical Employment Classification category would be downgraded [to] J31 to give 12 months of not deployable time to focus on welfare.²⁶⁵

268. This means that if a member retains their total hours but is scheduled to work at specific times to avoid contact with an alleged or convicted perpetrator for more than 4 weeks, they may be unable to deploy for 12 months. As discussed in Chapter 4, Postings and deployments, this can have immediate financial and longer-term career consequences.
269. In the event a victim and their commanding officer agree that a change in working hours or an alternative posting is the most effective way to protect their health and wellbeing, this should not result in any form of career penalty. At the same time, it is important to preserve their privacy and avoid identifying them as a victim of sexual misconduct. We note there are other reasons where alternative postings or a change in working hours may be needed, such as domestic violence or family reasons.
270. The ADF should develop a 'neutral' label such as 'compassionate reasons' to signify where a change in working hours or a short-notice or out of cycle posting has occurred. This would protect individual privacy and clearly signal no career penalty should apply. Similar amendments should be made to the military employment classification (MEC) system and guidance to promotions boards.
271. Information provided by Defence also highlighted a range of systemic constraints that may jeopardise victim safety:

CM-N [Career Management Navy] rely on commanders and managers to ensure that the respective CM [Career Manager] is notified when the co-location of victims and offenders is not to occur or is in the best interest of the individual and service ...

It is important to note that the present Human Resources system (PMKeyS) does not have the functionality to collect and manage sexual misconduct information. As a sensitive issue, and to protect the identity of victims of sexual misconduct, records of incidents and offenders are not retained in career management records. **Equitable management for the posting location of victims and offenders beyond the initial posting cycle is not supported by current record management systems.**

Similarly, Navy has no ability to inform Defence Housing Australia of such circumstances, and therefore has no control over where the victim and offender reside within the same posting locality. This would need to be resolved at the unit level, in consultation with Defence Housing Australia, Directorate of Navy Entitlements, and Career Management – Navy if such circumstances developed, and usually only becomes known after posting and removal action has occurred.²⁶⁶

272. Group Captain James confirmed she was aware of all of these constraints, and that the ADF leadership was also aware and ‘working already to provide a solution’. Concerningly, she said at least one of these constraints, relating to victims and perpetrators being posted together, ‘has been highlighted since the Broderick review [in 2012] and it’s still something that they’re working to solve’.²⁶⁷
273. These systemic issues have significant consequences for individual victims. Professor Ben Wadham told us that through his work he knew of ‘a few cases, where women have experienced sexual assault and then being posted with the perpetrator’.²⁶⁸
274. Systemic constraints that prejudice victim safety must be addressed as a matter of priority. It is unacceptable that ADF members are subjected to sexual misconduct at work, including sexual assault, and there are insufficient systems in place to ensure they do not come into contact with the perpetrator in the event the perpetrator is retained in service. While it is positive that ADF leaders are aware of these issues and a solution is being worked on, given at least one of these constraints has been known for more than a decade, there needs to be sufficiently robust accountability in place to ensure these problems are actually solved.

Recommendation 19: Protect victims of sexual misconduct from disadvantage over the course of their careers

To ensure there are no inadvertent career consequences for victims of sexual misconduct and to support the safety of victims over the course of their careers, Defence should:

- (a) develop a neutral label to signify where a change in working hours, or a short-notice or out-of-cycle posting, has occurred to protect a member’s health and wellbeing, in a way that protects individual privacy and clearly signals that no career penalty should apply. Similar amendments should be made to the military employment classification system and in guidance to promotions boards
- (b) report to the Minister for Defence Personnel by no later than 30 June 2025 on whether career management, human resources and Defence housing systems have been updated to ensure victims of sexual misconduct are not posted with their perpetrator/s over the course of their career.

8.5 Sexual offences in the ADF

275. Breaches of Commonwealth and Australian Capital Territory (ACT) legislation, including sexual offences, can be investigated and prosecuted as disciplinary offences under section 61 of the *Defence Force Discipline Act* (Cth) (DFDA). The High Court has confirmed that ADF members, both on and off duty, can be prosecuted for offences under the DFDA, whether the offences were committed against serving members (on or off duty) or civilians.²⁶⁹
276. Part 3 of the *Crimes Act 1900* (ACT) (the Crimes Act) governs sexual offences. It includes sexual assault in the first, second and third degrees, and engaging in sexual intercourse without consent. Annexure 8.3 lists the provisions of the Crimes Act and the *Commonwealth Criminal Code Act* (1995) used to prosecute sexual offences under the DFDA. Defence has told us the most common sexual offence prosecuted is an act of indecency without consent.²⁷⁰
277. As the Crimes Act requires positive consent for an act to be lawful, this means that ‘sexual offences under the DFDA apply a common standard of positive consent across Australia, regardless of the law on consent in the relevant State or Territory where the offence occurred’.²⁷¹
278. We note the sexual offences category does not include intimate image abuse or stalking, which Defence categorises as ‘related offences’. However, these offences still fall within Defence’s overall definition of sexual misconduct.²⁷²

8.5.1 Investigating sexual offences

279. The Joint Military Police Unit (JMPU) is responsible for investigating sexual offences under the DFDA. Defence policy states investigations will only proceed with the victim’s consent:

JMPU operates in a person-centred environment where the wishes and interests of the complainant are paramount. JMPU will provide complainants with options for further actions. Those options include investigating the matter, providing information for a future investigation should the complainant wish it, or taking no further action. JMPU is the primary liaison point between Defence and civilian police. JMPU, on the request of the complainant, will facilitate notifying and referring an incident to the relevant civilian police service where they also have jurisdiction within Australia. JMPU will obtain evidence and information in investigations where the complainant wishes to proceed with an investigation. All military police actions will cease where complainants do not wish for any further action to take place.²⁷³

280. Defence provided the following about the JMPU's specialist training into investigating sexual offences:

Following the introduction of the Technical Development Program (TDP), the Military Police (MP) gained training and experience within the field of sexual offence investigations through the provision of training by State/Territory Police. Only those trained through the program will investigate all sexual offences, thereby ensuring a higher level of consistency and quality in the investigation of such cases, and improve the prospect of a successful prosecution of the perpetrator.

The content of such training includes:

- (a) legislative requirements and the identification of offences
- (b) the interviewing of victims (including the effects of trauma on memory)
- (c) understanding forensic issues/considerations and collection of forensic evidence from the victim, the suspect and the scene
- (d) recognising and providing avenues of victim support preparation of vulnerable witnesses in the prosecutorial process.

Such specialist training is normally proffered to an individual after consolidation of general investigative experience (following qualification as an ADF Investigator), and successful completion (and consolidation) of the Scene of Crime Examiner Course (provided by Canberra Institute of Technology).²⁷⁴

281. Defence told us not every base has a JMPU officer trained in investigating sexual offences, but investigators can travel to bases as required:

There is no Defence policy or operational guidance that requires a JMPU Officer trained to investigate sexual offences to be present at every base in Australia.

[The] JMPU does not have a physical presence on every base in Australia. However, [the] JMPU is structured in such a way that there are JMPU members trained to investigate sexual offences available to travel to every base in Australia should the need arise.²⁷⁵

282. The IGADF provided us with information about professional standards complaints relating to the JMPU between 10 February 2022 and 10 July 2023. These included complaints related to the conduct of officers themselves, as well as their investigation of reported sexual offences. For example:

- A JMPU officer 'behaved inappropriately towards members of a Ship's company', including sexual harassment – administrative action was taken.²⁷⁶
- JMPU investigators reportedly 'failed to collect evidence (CCTV footage) in a sexual assault matter' – matter ongoing.²⁷⁷
- A JMPU officer made 'inappropriate comments of a sexual nature (a gang rape 'joke') towards members of the Bridge team' – administrative action was taken.²⁷⁸

- A JMPU officer reportedly failed to follow ‘incident reporting procedures following a complaint of sexual misconduct within Ship’s crew’ – matter ongoing.²⁷⁹
- A JMPU officer was reported to have ‘inappropriately conducted an interview with a possible respondent in a sexual misconduct matter’ – matter ongoing.²⁸⁰
- JMPU officer reportedly ‘made inappropriate comments (rape ‘joke’) to a junior’ officer – matter ongoing.²⁸¹

283. With one exception, the complaints listed above were directed at JMPU members posted on Navy ships. All were made in a little over a year, and raise questions about whether all JMPU officers are effectively applying their specialist training. We note some matters were ongoing and draw no conclusions as to their outcome.

284. However, we also heard positive reports of JMPU’s investigations of sexual offences. Reverend Dr Coleman reflected on JMPU’s investigation of her complaints, stating:

I was actually really impressed. They had an exceedingly well thought out trauma-informed approach. They had me meet with a social worker. The investigators came to my house in plain clothes. They were kind but vigorous in their investigation, and I was actually exceedingly impressed with the job that they did. They did a great job.²⁸²

JMPU has limited investigative powers compared to civilian police

285. The IGADF Inquiry noted there were limits to the JMPU’s powers to investigate sexual offences compared to civilian police, but did not detail the differences. The inquiry report stated:

Some witnesses expressed frustration at the inability of JMPU to receive evidence directly from civilian police, or that JMPU were unable to exercise the same law enforcement powers of civilian police.

One investigator said: As it stands, should a victim of a sexual offence elect for MP [Military Police] to conduct the investigation, as opposed to State/Territory Police, it would be reasonable to presume that the victim is of the belief that MP have access to all and any investigative tool that a police agency would have access to. We are after all, representing to the victim that an MP investigation is a viable option if they do not feel comfortable in taking the matter to police, or if the police choose not to investigate. As part of this communication process to the victim, they are not informed that MP do not have the ability to carry out a full and thorough investigation due to the severe lack of resources and legislative backing to allow that to happen. To do so would indeed undermine the criminal investigative ability of MP.

Rather than seeking to amend the DFDA to increase JMPU’s powers, the inquiry is of the view that investigators communicate the limits of their powers to both commanders and complainants.

The inquiry is conscious that this investigator's comments may not be representative of JMPU practice as one complainant in her submission said: 'JMPU did explain to me that they do not have the same level of jurisdiction as NSW Police did, which was part of the reason they subtly "encouraged" me to refer the case to NSW Police'.²⁸³

286. Regardless of whether a sexual offence is prosecuted in the military or civilian jurisdiction, the burden of proof is high – beyond reasonable doubt. Obtaining forensic evidence, or any other evidence, at the earliest opportunity is vital to securing a conviction.
287. We asked Defence to describe the difference between the JPMU's powers to investigate a sexual offence compared to civilian police. Defence provided the following response:

The following State/Territory police powers cannot be used by JMPU:

- Declare a crime scene (allows for giving of directions to leave/prevent entering/perform necessary functions)
- Surveillance (Telecommunication interception & access / Listening devices)
- Compel the provision of DNA/Specimens
- Compel the provision of PIN/Password for electronic devices
- Decision to charge (Command/ODMP [Office of the Director of Military Prosecutions] decision)
- Initiate proceedings (Command/ODMP decision)
- Video recorded interview with victim to be utilised as evidence-in-chief in civilian proceedings
- Protection Orders (able to initiate a Protection Order on behalf of the victim).

JMPU can conduct searches on Defence property under warrants issued through the DFDA and can conduct searches under warrant more generally in other locations under warrants issued through the *Regulatory Powers (Standard Provisions) Act 2014*. However, the powers of search under a regulatory powers warrant are more limited than other warrants regarding the use of force and forced entry to premises.²⁸⁴

288. The limitations of the JMPU's powers compared to civilian police can have consequences for evidence-gathering during an investigation, and for victims during court proceedings. While sexual offences can be referred to civilian police for investigation, this does not always occur.

Sexual offences can be referred to civilian police

289. Cases of 'penetrative sexual assault' can be referred to civilian police for investigation. That is because the ADF, through its Police Investigation Procedures, recognises the civilian police are 'generally best placed to investigate' them. However, referring a case should only occur with the victim's consent. The procedures state:

While the DFDA provides for the Office of the Directorate of Military Prosecution (ODMP) to seek consent from the Commonwealth Director of Public Prosecutions (CDPP) to prosecute offences of treason, murder, manslaughter, bigamy, and offences of penetrative sexual assault (or any attempt to commit the aforementioned offences), it does not necessarily follow that MP must refer such allegations to civilian police. Nevertheless, it is acknowledged that civilian police are generally best placed to investigate such offences, noting that they regularly deal with these incidents and have the experience, resources and legislation to provide the best options for a successful prosecution, while also providing access to support programs, such as Victims of Crime.

JMPU has exchanged letters with each of the State/Territory police agencies formalising the intent to strengthen relations and interoperability between their respective organisations with regard to the conduct of investigations and other policing matters. This includes, but is not limited to, formal arrangements for the referral of allegations for investigations between participants.

Any allegation considered by MP for referral to civilian police needs to be undertaken with the full knowledge and consent of the complainant/victim, particularly victims of sexual assault in accordance with the victim-centric, trauma-informed approach adopted by JMPU. That decision does not prevent MP from obtaining full details of the incident from a victim/witness, unless doing so would prejudice the civilian police investigation.²⁸⁵

290. We asked Defence to describe the circumstances in which JMPU refers a sexual (or related) offence to civilian police for investigation, other than when a victim indicates this is their preference. Defence responded:

With exception to those circumstances prescribed by law (e.g. offences involving minors, family domestic violence within NT), **JMPU does not refer sexual or related offences to civilian police for investigation.**

In all other circumstances, civilian police do not accept third-party reports, which means that the victim needs to report the incident to civilian police in any event. Acting in accordance with trauma-informed principles, JMPU would only provide advice and support to the victim including in relation to the victim's engagement with civilian police, and any support actions taken would be with consent of the victim.²⁸⁶

291. It is challenging to reconcile this response with the guidance in the Military Police Investigation Procedures, which expressly deals with referring penetrative sexual assaults to civilian police. As noted above, the way Defence reports on sexual assaults does not enable a clear understanding of the outcomes of reports made to the JMPU, and does not provide a clear picture of the number of sexual assault reports that were referred to civilian police.

8.5.2 Prosecuting sexual offences

292. The Director of Military Prosecutions is an independent statutory officer appointed by the Minister for Defence. The Director decides whether to prosecute a reported sexual offence, and the mode of trial for the accused: both Courts Martial and Defence Force Magistrates have jurisdiction.²⁸⁷ However, prosecuting certain sexual offences in the military justice system requires the consent of the Commonwealth Director of Public Prosecutions – specifically, offences under *Crimes Act 1900* (ACT) sections 51 to 55 relating to sexual assault and sexual intercourse without consent.²⁸⁸

293. Sexual offences are charged under DFDA section 61 and are subject to the Crimes Act which has no time limit on reporting or prosecuting sexual offences.²⁸⁹ Given the nature of sexual offences and the associated trauma, it is not uncommon for victims to report offences years after they have been committed.

Over the past 5 years, the Director of Military Prosecutions has not prosecuted the majority of sexual offences

294. Defence provided data on the number of sexual offence matters the Office of the Director of Military Prosecutions (ODMP) received that were not prosecuted, and the reasons why. Table 8.4 shows the numbers of sexual offences referred to the ODMP between 1 January 2018 and 1 October 2023 and how it dealt with them. It shows that, excluding the small number of current matters and appeals, 58% of sexual offences were not prosecuted.

Table 8.4 Sexual offence matters ODMP received, January 2018 to October 2023

	2018	2019	2020	2021	2022	2023	Total
Do not prosecute	9	25	14	12	26	18	104
Charged	8	20	12	14	19	3	76
Current matters						7	7
Appeals	1	-	1	1	1	-	4
Total	18	45	27	27	46	28	191

Source: Exhibit JJ-01.009, Department of Defence, Response to Notice to Give, NTG-DEF-213B, Annexure B, DEF.9999.0151.0014 at 0014.

295. Table 8.5 shows the reason 104 sexual offence matters were not prosecuted, and the nature of the reported offence.

Table 8.5 Reasons sexual offence matters not prosecuted, January 2018 to October 2023

Reason not to prosecute	Aggravated sexual assault	Non-aggravated sexual assault	Non-assaultive sexual offence	Total
To be dealt with as a criminal matter	4	5	-	9
Summary prosecution	1	3	6	10
Not in the interests of justice	1	1	1	3
Not in service interest	-	22	6	28
No prospect	8	35	11	54
Total	14	66	24	104

Source: Exhibit JJ-01.009, Department of Defence, Response to Notice to Give, NTG-DEF-213B, Annexure B, DEF.9999.0151.0014 at 0015–0018.

296. More than half of the matters that were not prosecuted were due to the ODMP's view there was no reasonable prospect of a conviction being secured. That prosecution was 'not in service interest' was the second most common reason, and includes where the victim did not want the matter to proceed.²⁹⁰

297. We asked what criteria the ODMP uses to decide whether to prosecute a sexual offence, including that prosecution is 'not in service interest'. Defence provided this 'non-exhaustive list of factors' that the ODMP applies to all offence types (not just sexual offences):

- the seriousness of the offence
- deterrence
- the effect upon morale
- delay in dealing with matters
- consistency and fairness
- operational requirements (noting that these would only justify a decision not to prosecute in 'the most exceptional cases')
- the interests of the complainant
- the nature of the accused (noting that in sexual offences, 'experience, seniority and position of the accused may be considered aggravating features')
- prior conduct
- when the accused is, or is about to be, no longer a member of the ADF.²⁹¹

Sexual offence matters had 68% average conviction rate

298. As Table 8.6 shows, 76 sexual offence matters were prosecuted between 1 January 2018 and 1 October 2023. Table 8.6 shows the outcome of these matters, noting one member can be charged with multiple offences.

Table 8.6 Outcome of sexual offence charges, January 2018 to October 2023

Offence type	Guilty	Not guilty	Total
Aggravated sexual assault	0	3	3
Non-aggravated sexual assault	25	14	39
Non-assaultive sexual offence	27	7	34
Total	52	24	76

Source: Exhibit JJ-01.009, Department of Defence, Response to Notice to Give, NTG-DEF-213B, Annexure B, DEF.9999.0151.0014 at 0015–0018.

299. Overall, there was an average conviction rate of 68% (52 of 76 offences). When this is broken down by offence type, the conviction rate is:
- zero per cent for aggravated sexual assault
 - 64% for non-aggravated sexual assault
 - 79% for non-assaultive sexual offences.

8.5.3 Consequences for perpetrators

300. Following on from our examination of prosecutions, we look at punishments imposed under the DFDA and the disciplinary system. The ADF can also take administrative action in response to a sexual offence, which we examine later.
301. We requested Defence provide data on punishments applied for sexual offence convictions. Defence provided the data, but it was not classified by the type of offence (aggravated and non-aggravated or assaultive and non-assaultive). Consequently, we have been unable to match this data with the guilty outcomes listed in Table 8.6. However, the data provides enough information to make some general observations.

Detention is rarely imposed as punishment for sexual offences

302. Dismissal from the ADF was a common form of punishment, but this did not occur in all cases. Alternative punishments included detention; forfeiture of seniority or reduction in rank; ‘severe reprimand’; and monetary fines.

303. Between 1 January 2018 and 1 October 2023, 43 members were convicted on at least one charge of a sexual offence (noting someone can be convicted of multiple offences), of whom 22 had a sentence that included dismissal from the ADF. Of the other 21 convicted perpetrators of sexual offences who were not dismissed, 14 (approximately 30%) remain serving.²⁹²
304. Over the same period, only six members convicted of sexual offences were detained at the Defence Force Corrective Establishment.²⁹³ In data provided to the Royal Commission on successful sexual offence prosecutions between 1 January 2018 and 1 October 2023, where the punishment applied was detention, the length of detention varied from 14 days (7 days suspended) to 120 days (up to 120 days suspended).²⁹⁴

Sentencing principles should focus on victim impact

305. DFDA section 70 requires a service tribunal to consider the need to maintain discipline in the ADF and civil courts' principles of sentencing.²⁹⁵ To the extent these principles require mitigating or aggravating circumstances to be taken into account, these circumstances must include:
- the person's rank, age and maturity
 - the person's physical and mental condition
 - the person's personal history
 - whether or not the person has previous convictions for service offences, civil court offences and overseas offences
 - if the service offence involves a victim, the person's relationship with the victim
 - the person's behaviour before, during and after the commission of the service offence
 - any consequential effects of the person's conviction or proposed punishment.
306. In the context of sexual offences we are concerned the only express mention of the victim is their relationship to the offender. While the DFDA does not prohibit a service tribunal from taking the impact on the victim into account as a mitigating or aggravating circumstance during sentencing, it also does not expressly require it. We consider this is out of step with sentencing principles for sexual assault offences in civilian courts.²⁹⁶ Given the significant emotional and physical trauma that results from sexual offences, this is a concerning omission.
307. In addition, the sentencing principles do not state how the victim's relationship to an offender might affect the punishment, which is common practice in civilian courts.²⁹⁷ Currently, the DFDA just says an offender's rank and their relationship to the victim may be mitigating or aggravating factors. In civilian jurisdictions, if there is a power imbalance between the offender and victim, this is generally considered an aggravating factor for sentencing purposes. Similar clarity is needed in the DFDA.

308. The Office of the Judge Advocate General has issued a Practice Note for prosecution and defence counsel to assist service tribunals to undertake sentencing action under the DFDA.²⁹⁸ The Practice Note states prosecution counsel should in all cases:
- (1) tender or call evidence from the convicted person's career management agency on:
 - (a) how the conviction alone and how the punishments of reprimand, severe reprimand, forfeiture of service/seniority, reduction in rank and detention will affect:
 - (i) capability
 - (ii) employability in the convicted person's category/corps/specialisation/trade
 - (iii) future promotion prospects
 - (b) whether the convicted person would move to a different pay grade if reduced in rank
 - (2) for discipline history:
 - (a) advise the tribunal of the absence of a record of previous convictions; or
 - (b) tender or call evidence of the existence and details of previous convictions – if tendering material, this should not contain irrelevant and potentially prejudicial material (eg, a report/record showing investigations or charges that did not result in a conviction).²⁹⁹
309. The Practice Note also states that in all cases, defence counsel should tender a 'Pre-Sentence Report' which sets out information about the accused. This includes their education and trade qualifications, marital status, dependants, income and financial means. The report should note if other supporting information is provided, including medical or social worker reports, behaviour reports from supervisors or commanders, character references, service history and a report about the 'potential consequential effects of conviction and/or punishment'.³⁰⁰
310. The Practice Note does not require prosecution counsel to invite the victim to make a Victim Impact Statement. It only says certain *Crimes Act 1914* (Cth) provisions apply if a Victim Impact Statement is relied upon.³⁰¹ This tends to reinforce the DFDA sentencing principles' focus on the impacts of a conviction and punishment on the offender, rather than the impact of the offence on the victim.
311. Civilian courts must consider the impact of a sexual offence on a victim, but it is up to the victim whether they make a statement. For example, in New South Wales, victim impact statements must be considered for prescribed sexual offences (among others) and can include details of personal harm, emotional suffering or distress, harm to relationships with other people, and any economic loss or other harm that arises from these areas.³⁰²

312. Victim impact statements in relation to sexual offences under the DFDA must comply with the *Crimes Act 1914* (Cth). It allows an oral or written statement that must:
- be made by the victim, a member of their family (if the court gives leave) or a person appointed by the court
 - describe the impact of the offence on the victim, including the harm they suffered as a result.³⁰³
313. The *Crimes Act 1914* (Cth) states ‘no implication is to be drawn from the absence of a Victim Impact Statement’.³⁰⁴
314. Given the significant impact of sexual offences on a victim’s health and wellbeing, DFDA sentencing principles must be amended to align with contemporary civilian criminal jurisdiction standards and remove any potential ambiguity. At a minimum, service tribunals should be expressly required to consider the impact of a sexual offence on a victim as a factor during sentencing, and prosecution counsel should be required to invite a victim to make a Victim Impact Statement for the service tribunal to consider. Making a statement should not be compulsory, but the invitation to make one should be. The victim should be able to opt to read the statement aloud in a closed or open court, as is the case in New South Wales.³⁰⁵
315. Even if the Australian Government accepts our recommendation that all members convicted of sexual offences are mandatorily discharged (see Recommendation 22), it is still essential that service tribunals consider the impact on victims when sentencing offenders. Other punishments, particularly imprisonment, must reflect the seriousness of a sexual offence and the resulting harm.

Recommendation 20: Amend the legislation related to sentencing perpetrators of military sexual offences

The Australian Government should amend Section 70 of the *Defence Force Discipline Act 1982* (Cth) to:

- (a) expressly require service tribunals to consider the impact of a sexual offence on the victim as a factor during sentencing, including a victim impact statement if one has been made, and allow the victim to read their statement aloud if they choose to do so, in a closed or open court
- (b) make it clear that if an offender is of higher rank than a victim, this should be considered an aggravating factor for the purpose of sentencing.

The Australian Defence Force Chief Judge Advocate should amend Practice Note 6 – Part IV Sentencing to require the prosecution counsel to invite victims to make a victim impact statement for consideration by the service tribunal during sentencing.

Administrative action for sexual offences

316. Administrative action can also be taken in response to a sexual offence, whether there has been a conviction or acquittal under disciplinary or criminal proceedings. Administrative action focuses on whether a member remains suitable for service.

317. Defence policy states:

A commander or manager may consider initiating formal administrative action against a respondent while an incident of sexual misconduct is under investigation, while criminal or disciplinary proceedings are pending, or after those proceedings have concluded. A conviction or acquittal for an offence does not prevent administrative action being taken for a sexual misconduct matter that is the subject of those disciplinary or criminal proceedings. A decision whether or not to initiate administrative action may be reconsidered as required.³⁰⁶

318. For example, administrative action may be taken when:

- a sexual misconduct incident may not meet the criminal burden of proof under the DFDA or state or territory legislation (beyond reasonable doubt) but meets the administrative system burden of proof (on the balance of probabilities)
- a member has been convicted of a sexual offence under the DFDA and the commanding officer considers administrative action is also warranted
- a member has been convicted of a sexual offence by the civilian justice system (which would not involve a punishment related to the member's ADF service) and the commanding officer considers administrative action is also warranted.

319. The IGADF Inquiry report explained:

In addition to facing disciplinary action for sexual offences under the Defence Force Discipline Act or criminal consequences in civilian courts, members may be reduced in rank or terminated from the ADF if their continuing service is considered 'not to be in the interest of the ADF'.

Consequently, sexual misconduct is both a disciplinary or criminal offence against the person and unsatisfactory conduct which impacts on the ADF's interests. This potential impact on the ADF's functioning and standing more broadly is addressed through administrative action (separate from action under the DFDA). Since both avenues may be pursued, complainants and respondents face lengthy waits. Outcomes under the DFDA do not preclude later administrative action, which also applies a different standard of proof and different considerations.³⁰⁷

320. Defence provided us the following information on when action under both systems is warranted:

In some situations, both administrative and disciplinary action may be appropriate ... this has typically occurred when:

- there is both a single incident of significant misconduct which it is appropriate to deal with by disciplinary process, and that incident is the last of a series of events warranting consideration of the member's overall suitability for continued service. In this case, the disciplinary process overlaps with one part of the administrative process, but the administrative action is broader; or
- there is a single incident of significant misconduct which merits disciplinary action in order to maintain the discipline and order of military service, but that incident also indicates that the member is not suitable for further service.³⁰⁸

321. Defence cited 'indecent/sexual offences' and 'other forms of sexual misconduct' as 'typical examples of situations which could be managed under the DFDA and administratively'.³⁰⁹ Defence said common grounds for administrative termination for misconduct include 'conduct that amounts to a civil offence', and that 'sexual misconduct' is one of the 'most prevalent' types of civil offences.³¹⁰

322. The Military Justice Submission from Defence explained that disciplinary and administrative action serve two different purposes. Disciplinary action relates to imposing punishment on an individual, whereas administrative action is designed to protect ADF members from harm:

Administrative action may be initiated concurrently with, or consecutively to, disciplinary action. This is because they are different actions in nature and purpose. A disciplinary proceeding is punitive in character; it determines individual guilt beyond reasonable doubt, convicts if appropriate and decides on individual punishment according to strict legal criteria. Administrative sanctions have a protective character, that is they are designed to limit the harm or risk of harm to the ADF and its community of members from an individual's misconduct.

While the individual member may feel that an administrative sanction constitutes a punishment because of its impact on them, and the sanction requires facts about the individual's conduct to be established to the balance of probabilities, the purpose is not to punish the member for breaching discipline but to protect the ADF and its members, based on evaluative judgments about what is in the interests of the ADF. An administrative action that is imposed with a punitive purpose would be at risk of illegality for bad faith or improper purpose, and this would be subject to review in existing complaint processes.

Defence acknowledges that this is a high-level distinction in concept and purpose, and that there is overlap in effect given that both administrative and disciplinary components of the military justice system support good order and discipline in the ADF. This is why careful consideration should be, and is, given to concurrent actions.³¹¹

323. In cases where 'disciplinary proceedings resulted in an acquittal or in a punishment that did not include dismissal under the DFDA', Defence said:

A decision that the retention of a member is 'not in the interests of the ADF' for the purposes of section 24(1)(c) of the Defence Regulation 2016 is different to a decision as to whether a punishment of dismissal should be imposed after conviction for a specific disciplinary offence under the DFDA. They are separate statutory decisions, by separate statutory decision makers. **The decision to impose a punishment under the DFDA is guided by the principles of sentencing in Australian criminal law and constrained by those principles on the matters that may be taken into account. A decision maker who is determining whether the retention of a member's service is not in the interests of the ADF is required to take account different legislative reasons, including organisational factors about ADF capability and effectiveness, and exercises a broader discretion than the DFDA decision maker. Given these differences, it is possible that two decision makers, acting in good faith under these separate statutory schemes, could reach different conclusions.**³¹²

324. So if a member is convicted for a sexual offence under the DFDA but not dismissed as part of sentencing, their conviction can still lead to an administrative decision that their retention 'is not in the interests of the ADF' under Defence Regulation 2016 section 24(1)(c). This decision can be based on the behaviour that resulted in the conviction (in accordance with Defence Regulation 2016 section 6(2)(b)), without requiring additional or aggravating circumstances.

There are members convicted of sexual offences still serving

325. In response to compulsory notice, Defence told us 14 current serving members were convicted of a sexual offence against an ADF member between 1 January 2018 and 1 October 2023.³¹³
326. In addition, 17 current serving members have been convicted of an offence involving conduct of a sexual nature against an ADF member. This includes offences such as prejudicial conduct, assault, obscene conduct and non-consensual distribution of intimate images.³¹⁴ These offences are included in the broader category of 'sexual misconduct', but are not classed as sexual offences.
327. This means 31 current serving members of the ADF have been convicted of sexual and related offences.

ADF may take administrative action, including dismissal, where an offence is not prosecuted

328. Some members who were not prosecuted for sexual offences were involuntarily discharged from service or had lesser punishments imposed.

329. Defence provided data on administrative action it has taken against members who were not prosecuted for sexual offences in the disciplinary system. We note this data is not publicly reported and represents a point-in-time analysis. Some matters were still under consideration when it provided the data, and in other cases we could not determine the action taken as categories are not standardised. Therefore, this is indicative rather than a comprehensive summary of all administrative outcomes.
330. Of the 104 sexual offence matters not prosecuted by the Director of Military Prosecutions between 2018 and 2023, as set out in Table 8.5, the administrative action taken against the relevant members included:
- at least 13 members were dismissed on the basis of ‘not-in-service interest’
 - at least 13 members were subject to formal warnings
 - at least 13 members were subject to formal counselling.³¹⁵

Commanding officers face competing pressures when considering administrative action

331. The IGADF Inquiry highlighted the competing pressures commanding officers face when making decisions about punishments for sexual misconduct, including offences, in the administrative system. In some cases, commanding officers were clear that ensuring a safe workplace is critical to maintain Defence values and capabilities, while others sometimes considered that the benefits of retaining an offender outweighed the costs:

One CO [commanding officer] spoke of the link between the ADF’s policies on sexual misconduct and capability succinctly as ‘I need a safe and supportive workforce, and if it’s not, it impacts capability’.

Another CO took a more nuanced approach in this way: How does it affect capability? I come at it in two ways. One, it’s important in the Defence Force because we build our people and we want them to be good human beings. A team is not just a group of people, but a group of people who trust each other. Some might think ‘this is just another layer of bureaucracy which takes us away from core business, and it does affect capability’. We need to establish this level of awareness. No, it doesn’t affect capability. It’s important. We need to establish those behaviours and patterns. The other thing is the implementation of the policy can affect capability. If an individual has been involved, say as a respondent, and is subsequently terminated, then depending on their role, it may have an impact of capability. I’m dealing with an officer, who has taken 8 years to train as a helo pilot, \$2 [million] in terms of cost and time, and he’s now waiting for a decision on NTSC [notice to show cause] for termination. This impacts capability and we then have to deal with that when there is already a paucity of pilots. I’m not saying this has to drive the decision. [T]he decision is based on expectations we set and the values we hold, but this is how policy can impact capability.

When pressed whether commanders may weigh the balance between forgiving sexual misconduct and retaining a member who has a particular niche skill set or expertise, in favour of retention, another CO said this: That's very common, that sits in the level 2 of that managing bad behaviour. 'Yeah I know they did it, but they are my vertical launch SME I can't do without, there's a fleet-wide shortage of that sort of individual, let's come in soft so I can meet my mission.' He talks tough before he has to do it, but I would prefer not to sail my ship than do that.

Another senior officer commented there was more incentive to take action against an ADF respondent when the victim was also an ADF member. She referred to 'a case when an individual was a particular armament technician – one of only nine in the Air Force. He had gone to court three times for DV. The victim was not in the Defence Force. We kept him because of his skill sets'.

However, other senior officers were adamant that such a balancing act was historic. 'There was behaviour in the past "oh, he's a good bloke". But now, if it's assault, we don't care who you are or what you do, we treat you the same.' Another said, 'I know people would get away with stuff in the past, but if they did that today, they'd be sacked. Mel Hupfeld would sack them personally.'

VCDF [Vice Chief of Defence Force], as the accountable officer for military justice, put it bluntly: 'I start with my view – and confident it's the view of the Chiefs – there's no expensive fighter pilot whose performance is so critical to us that he or she is beyond the expectations we have of them to build healthy team culture'.³¹⁶

Commanders differed in their tolerance of misconduct, some insisting they would not tolerate it in any circumstances, others acknowledging there might be a trade-off with a member's performance. 'There was a second year who was given notice to show cause after several incidents. His alpha male behaviour had given him licence, especially since he did well in the field'.³¹⁷

Other commanders considered it would be difficult not to make that trade-off, depending on how critical the respondent was to the unit's success. As one put it, 'Skill sets do matter to the ADF, especially if the victim is not part of the ADF, even unconsciously'.³¹⁸

332. Commanding officers still face these pressures. One reason given why no administrative action was pursued following disciplinary action for a member convicted of an act of indecency without consent was their commanding officer 'determined [the] capability provided by the member is essential due to remote locality employment'. This occurred in 2023.³¹⁹

8.6 Sexual offences and the civilian justice system

333. DFDA convictions in the military justice system are not transferred to civilian criminal records, and the ADF does not have comprehensive data on members arrested, charged or convicted for a sexual offence in the civilian criminal justice system. There are clear safety implications on both sides.
334. Even where perpetrators are dismissed from service on the basis of a sexual offence conviction under the DFDA, they may not have a civilian criminal record – even though the DFDA relies on civilian criminal legislation for sexual offences. The DFDA enables Defence to disclose sexual offence convictions to a Commonwealth, state or territory authority.³²⁰ However, the Judge Advocate General believes this provision has never been used:

I understand no policy or procedure exists to facilitate its utilisation. In practice this may mean members who are convicted of ‘Territory offences’ (offences contrary to ACT criminal law prosecuted under s 61 DFDA), may transition to civilian life after serving the sentence with no recorded civilian conviction.³²¹

335. As discussed in Chapter 10, The ADF military justice system, this poses a serious risk to the broader Australian community.

The ADF does not know how many serving members have been convicted of sexual offences in civilian courts

336. The 2012 Review into the Treatment of Women in the ADF said:

The Review knows of at least one instance where a member was convicted of one count of indecent assault in a civilian court against another member of the ADF. He was sentenced to a term of imprisonment but the whole of the sentence was suspended for 18 months. The offender was retained by the ADF, and continues to serve. The victim in this matter has discharged from the ADF. **The ADF could not advise with certainty that there are no other current serving ADF members who are convicted sexual offenders.**³²²

337. Twelve years on, nothing has changed. Defence told us the ADF ‘does not have a complete and accurate record of serving members who have been convicted of a sexual offence under State or Territory legislation’.³²³ This is highly concerning, particularly as penetrative and other forms of aggravated sexual assaults are often referred to state and territory civilian police for investigation, as discussed in section 8.5.1.
338. An ADF member who has been ‘arrested, charged or convicted’ for a sexual offence in the civilian criminal justice system is obliged to inform their commander or manager.³²⁴ However, then Vice Chief of Defence Force (VCDF) Admiral David Johnston confirmed that if the member does not do so, there is ‘no mechanism for the states and territories civilian courts to automatically inform Defence that an individual has been charged’.³²⁵

339. Associate Secretary for Defence Mr Yannopoulos acknowledged members can lie by omission about civil convictions for actions during their time in service.³²⁶ The Associate Secretary agreed it is unacceptable the ADF relies on members to voluntarily disclose they have been convicted of sexual offences under state and territory legislation, and there are no additional safeguards in place. Mr Yannopoulos said 'it would be good' to receive this information from states and territories, but this had not been raised with him during his time as Associate Secretary.³²⁷

8.7 Shining a light on sexual misconduct: the way forward

340. Then Chief of the Defence Force (CDF) General Angus Campbell told us he 'does not tolerate sexual assault'. He 'expects appropriate action to be taken against any ADF member whose conduct has been proven to be out of alignment with the Defence Values and Behaviours'.³²⁸ The CDF states this:

is achieved through a combination of the application of Defence policy and the use of the military justice system by commanders and managers operating at all levels of the ADF.³²⁹

341. The Complaints and Resolutions Manual (CARM) states 'sexual misconduct is unacceptable in Defence'.³³⁰ The IGADF Inquiry report notes ADF senior leaders 'appear in training videos to emphasise sexual misconduct as a breach of Defence values'.³³¹
342. These important statements of principle need to be reinforced by much clearer and more robust policies that ensure perpetrators of sexual misconduct are held to account in practice.

8.7.1 Presumption of discharge for sexual misconduct

343. We have heard from victims through submissions and private sessions that punishments for sexual misconduct, including sexual offences, are often considered to be too lenient. Victims and others told us offenders continue to serve in the ADF, resulting in ongoing trauma for the victim and the risk of further offending.

I am a ex-serving member of the Royal Australian [redacted]. I served over 14 and a half years and have deployed twice to the Middle East. I have seen my friends and family, also I have experienced suicide myself. Some of the biggest factors for some are the culture and the lack of care or follow-through of investigations into poor conduct or sexual assault that was swept under the carpet or had the victims painted out to be the perpetrator.

In my time of service I have seen women sexually assaulted and been victimised by the chain of command. Resulting in the perpetrators being given the lowest punishment possible and allowing them to reoffend. Due to the culture within Defence males get female co-workers so drunk they can't walk or talk properly then assault them when they are passed out.

At the start of the year, videos are shown of what is acceptable behaviour towards drinking and conduct. The majority of members laugh and make rape jokes about it ... The culture needs to change, not only towards drinking but how the day-to-day life affects others in a toxic workplace.³³²

344. There is insufficient consistency or oversight of decisions commanding officers make regarding the consequences for sexual misconduct, particularly sexual offences.
345. The VCDF was the Accountable Officer for the Military Justice System until November 2023, when this responsibility transferred to the Chief of Personnel. However, then VCDF Admiral Johnston told us he did not have 'any authority or oversight' of command decisions about whether a member convicted of committing a sexual offence against another ADF member should be retained in service.³³³
346. The Associate Secretary said he had not considered from a policy perspective what it means to have serving members convicted of sexual offences remaining in the ADF, but undertook to do so.³³⁴ When asked whether retaining members convicted of sexual offences significantly impacts the ADF's ability to attract and retain new members, particularly women, the Associate Secretary said this had not been included in the data presented to Defence committees associated with recruitment or retention.³³⁵
347. In 2022, the Navy issued the 'Process for Termination of Service in the Defence Force for Unacceptable Behaviour of a Sexual Nature' directive. It states a Notice of Termination of Service must be issued when an administrative, criminal or disciplinary process has made a substantiated finding of unacceptable behaviour of a sexual nature.³³⁶ The Navy directive states:

An allegation of a sexual offence need not result in a conviction in order to be unacceptable behaviour of a sexual nature. This is due to the difference between the criminal ('beyond reasonable doubt') and the civil ('on the balance of probabilities') standards of proof. Furthermore, the conduct itself may be part of a larger interaction that may not be criminal but unacceptable in an ADF contexts. For example, inappropriate interactions between individuals of different ranks within the same chain of command. Ultimately, for this Directive to apply, there needs to be a finding either by a criminal/disciplinary tribunal or administratively by Command that substantiates the allegation.³³⁷

348. This recognises certain types of conduct mean that a member's retention is not in the ADF's interests, even where the criminal standard of proof has not been met.

349. The directive applies to sexual offences, sexual harassment, intimate image abuse and stalking. Command is instructed to seek legal advice if an allegation of sexual misconduct is substantiated but falls outside these criteria.³³⁸
350. The decision to terminate service rests with Navy headquarters. It does not require any additional or aggravating behaviour beyond a substantiated finding of unacceptable behaviour of a sexual nature.³³⁹ The directive states when a commanding officer is 'of the view a member should be retained, they are to provide a written recommendation, specifically addressing why it is in the interests of the Defence Force to retain the member'.³⁴⁰
351. When asked, then-Vice Chief of Defence Force Admiral Johnston was unaware whether Army or Air Force had a similar directive.³⁴¹ However, during the procedural fairness process Defence told us that:

ADF Headquarters has been tasked by the CDF to consider how to achieve a similarly consistent approach across all Services and groups through issue of a CDF directive on mandatory consideration of termination of service and suspension in categories of circumstances, including a member being convicted of a serious offence. This work is in draft form and is being overseen by the Military Justice Steering Group.³⁴²

352. This is a step in the right direction, but does not tell us what is considered to be a 'serious offence' in the context of sexual misconduct, nor the consequences that would apply.
353. A policy introduced in the UK, also in 2022, provides a strong benchmark. The UK Armed Forces introduced a 'Zero Tolerance to Unacceptable Sexual Behaviour: A Victim/Survivor Focused Approach'. The policy states:

Unacceptable sexual behaviour seriously harms victims/survivors ('victims'), adversely impacts unit cohesion and operational effectiveness, and undermines public confidence in the Armed Forces. There is no place in the UK Armed Forces for people who display unacceptable sexual behaviour, which includes those who commit sexual offences.

...

There is a presumption that anyone in the Armed Forces who is found to have behaved in an unacceptable way that is sexual in nature, will be discharged. If, exceptionally, someone is retained but they go on to behave in a sexually unacceptable way a second time, their discharge is mandatory.³⁴³

354. The UK Armed Forces' definition of 'unacceptable sexual behaviour' is broad, and is similar to the ADF's definition of sexual misconduct.³⁴⁴ The policy applies the balance of probabilities administrative standard of proof:

The standard of proof that must be met to determine if unacceptable sexual behaviour took place is on the balance of probabilities, which is the administrative standard and is lower than the criminal standard which is beyond reasonable doubt. For that reason, the following situations may provide sufficient evidence of unacceptable sexual behaviour to engage this policy:

- Potential sexual offences initially reported to the police which are discontinued during investigation, or which having been considered by the [Service and Crown prosecuting authorities] are not prosecuted as there is not considered to be a Realistic Prospect of Conviction of a criminal offence.
- Potential sexual offences prosecuted at Court Martial or in the civilian criminal justice system, for which the Defendant is found not guilty (beyond reasonable doubt) of a criminal offence.

In these situations, regardless of the lack of prosecution or finding of not guilty, there may still be evidence of unacceptable sexual behaviour (including a subsequent civil conviction), and this policy must be applied to consider whether the presumption of discharge is triggered.³⁴⁵

355. The policy lists the following mitigating and aggravating factors to consider before a decision to discharge is made:³⁴⁶

Mitigating Features

- Low level of harm to victim
- Low level of culpability
- Youth or inexperience of the perpetrator. For example, a person under 18 who is still in Phase 1 training.
- Positive engagement of the perpetrator in the investigation process.
- Perpetrator clearly understands the seriousness of their behaviour, indicates genuine remorse and is capable of changing their behaviour.
- Perpetrator's willingness to engage with training in order to learn about appropriate behaviours.

Aggravating Features

- Greater harm to victim
- Higher culpability
- Age or seniority of the perpetrator.

- Impact on unit cohesion. Retaining a person convicted of a sexual offence or known to have behaved in an unacceptable (sexual) manner can have a detrimental impact on teamwork, working relationships and morale.
- Operational effectiveness is undermined
- Perpetrator's lack of appreciation of seriousness of behaviour, lack of remorse and an unwillingness to change behaviour.
- Perpetrator's unwillingness to engage in training to learn about appropriate behaviours.
- Behaviour was of a kind that was problematic within a unit and specific action had already been taken to address it, including warnings to personnel, yet the perpetrator continued to behave in that way.³⁴⁷

356. However, the UK policy makes it clear a decision to retain a member found to have committed 'unacceptable sexual behaviour' is the exception, not the rule.³⁴⁸

357. It is mandatory for commanding officers to apply this policy 'whenever sexually unacceptable behaviour is found to have taken place'. A 2-star ranked officer has to approve the decision to discharge or retain the member. The policy includes accountability mechanisms and a continuous improvement requirement:

Discharge statistics for unacceptable sexual behaviour must be submitted to Ministers on a 6-monthly basis. In support of the submission, each Service will provide an overview of the themes and lessons learned from the cases, along with details of any specific action being taken to address those themes and lessons. This will enable monitoring to ensure consistent application of this policy across Defence, allow analysis of the data and enable holding to account.³⁴⁹

358. Compared to the UK Zero Tolerance Policy, the Navy directive is missing some important elements as:

- there is no requirement to provide regular reports on discharge statistics to ministers, including on common themes and lessons learned
- it captures a narrower range of behaviours
- the rank of the approving officer is unclear.

359. The Navy has shown clear leadership and is to be commended for the directive. A similar approach should be adopted across the ADF, and should include the UK policy's expanded scope of behaviours and additional oversight mechanisms.

Recommendation 21: Implement a ‘presumption’ of discharge for Australian Defence Force members found to have engaged in certain forms of sexual misconduct

The Chief of the Defence Force should issue a directive providing for a presumption that anyone in the Australian Defence Force (ADF) who is found to have engaged in certain forms of sexual misconduct will be discharged.

- (a) The directive should apply to specified forms of sexual misconduct including, but not limited to, sexual harassment, sexual offences, related offences including intimate image abuse, stalking, and any other offence involving conduct of a sexual nature against an ADF member including prejudicial conduct, assault and obscene conduct.
- (b) The standard of proof is the balance of probabilities. For the directive to apply, there needs to be a finding, either by a criminal/disciplinary tribunal or administratively by command, substantiating that sexual misconduct has occurred. Where a sexual offence allegation has been made but has not proceeded to prosecution, or has been prosecuted but has not resulted in a conviction, the behaviour must be assessed on the balance of probabilities to determine whether the directive applies.
- (c) Procedural fairness should be afforded to the member before a decision on whether to retain or discharge them is made. The directive should provide guidance on factors to be taken into account by the decision-maker. The decision must be approved by the relevant service chief.
- (d) Discharge statistics related to decisions made under the directive should be provided annually to the Minister for Defence and the Minister for Defence Personnel. Statistics should be disaggregated by service and be accompanied by an analysis of common themes, lessons learnt, and actions taken in response.

360. The UK Armed Forces has also issued a ‘Zero Tolerance to Sexual Offences and Sexual Relationships Between Instructors and Trainees’ policy, which states:

When a person is convicted of a sexual offence or an instructor is found to have engaged in a sexual relationship with a trainee, their discharge is mandatory.³⁵⁰

361. Mandatory discharge applies to all members of the UK Armed Forces convicted of prescribed sexual offences, and applies regardless of whether the victim is a serving member or a civilian.³⁵¹ The policy is based on the following rationale:

Sexual offending is a crime, harms people, adversely impacts unit cohesion and operational effectiveness, and undermines public confidence and trust in the UK Armed Forces. There is no place in the UK Armed Forces or MOD [Ministry

of Defence] Civil Service for people who commit sexual offences. Additionally, instructors or personnel in a position of authority, who engage in sexual relationships with trainees or recruits, are abusing their position of trust and may be committing an offence ...

The offences above may be tried by Court Martial, in which case dismissal is a punishment available to the Court. Where, despite the individual having been found guilty, the Court Martial Board chooses not to award dismissal, the Service with Full Command of the individual shall administratively discharge them in line with this policy.³⁵²

362. It is critical that sexual offences in the ADF are treated with similar gravity. As the UK Armed Forces has recognised, sexual offending has a range of significant and negative consequences to both individuals, teams and military capability. Critically, for the purposes of our inquiry, sexual offending (and other forms of sexual misconduct) are directly linked to suicide and suicidality. We therefore consider similar protections should apply in the ADF. However, during the procedural fairness process the Commonwealth submitted there are legislative barriers in Australia:

As a matter of law, Defence policy cannot mandate automatic termination of service of a member convicted of a sexual offence. The Defence Regulation 2016, through section 24(1)(c), permits individual administrative decisions to be made to terminate a member's service when their retention is not in the interests of the ADF. The inclusive definition of that phrase in section 6(2) includes reasons relating to a 'member's behaviour (including any convictions for criminal or service offences)'. However, such decisions must comply with administrative law principles, including fair process and non-prejudgment of outcome ... Legislative change would be required to achieve mandatory administrative termination of service, or dismissal under the DFDA, for members convicted of service offences.³⁵³

363. In the time available, we have not been able to undertake a detailed analysis of the differences in legislation governing the UK Armed Forces and the ADF. We endorse the UK policy of mandatory discharge for sexual offence convictions in principle, and recommend that Defence seek further legal advice on the legislative barriers, if any, to introduce mandatory discharge for ADF members convicted of sexual and related offences in the military and civilian criminal justice systems.

Recommendation 22: Adopt a policy of mandatory discharge for Australian Defence Force members convicted of sexual and related offences

Defence should adopt a policy of mandatory discharge for Australian Defence Force members convicted of sexual and related offences (including stalking and intimate image abuse) in the military and civilian criminal justice systems, subject to further legal advice on the legislative barriers, if any.

8.7.2 More robust records of civilian and military sexual offence convictions

364. As discussed above, the ADF does not know how many serving members are convicted sex offenders. In 2024, this is shocking.
365. Similarly, members convicted of sexual offences in the military justice system do not have these convictions transferred to their civilian criminal record.
366. In Chapter 10, The ADF military justice system, we recommend improving communications between the ADF and state and territory authorities to ensure this type of information can be shared for all types of offences. However, given the nature of sexual offending and the danger it poses to the ADF workforce, and to civilian workplaces in the case of ex-serving members with DFDA convictions, sexual offence convictions must be prioritised and progressed as a matter of urgency.

Recommendation 23: Record convictions of sexual offences in Australian Defence Force records and civilian criminal records

As a matter of urgency, the Australian Government should:

- (a) ensure the Australian Defence Force has a complete and reliable record of all serving members who have been convicted of sexual offences and related offences (including stalking and intimate image abuse) in civilian courts
- (b) work with state and territory governments to ensure that civilian criminal records include convictions of sexual offences and related offences (including stalking and intimate image abuse) made under the *Defence Force Discipline Act 1982* (Cth).

8.7.3 Comprehensive public reporting is needed

367. The lack of publicly available data regarding sexual misconduct in the ADF undermines public trust and does not meet expectations for government transparency. The introduction of the CASE management system will enable the ADF to report on disciplinary and administrative outcomes for all forms of sexual misconduct, including demographic characteristics of victims and offenders.
368. As we have discussed throughout this chapter, the information published in annual reports, and reports from the Office of Director of Military Prosecutions (ODMP) and the Judge Advocate General, are disjointed, point-in-time records and do not sufficiently identify the nature and type of sexual offences. The 2021 IGADF Inquiry noted the importance of publishing this information as a form of deterrence, and

the 2012 Broderick Review agreed it should be in the public domain to hold the ADF to account. We agree. There is no reason this information cannot be reported in a form that enables trends to be identified and meaningful analysis to be undertaken, and to provide confidence that perpetrators of sexual misconduct in the ADF face appropriate consequences.

369. Our recommendation does not prevent the Judge Advocate General and ODMP from publishing separate reports, but their independence should not be used as a rationale for excluding critical data related to the outcomes of the military justice system. Similar data is available in much greater detail for the civilian justice system, and Defence should be no exception. Reporting should be conducted in a way that protects individual privacy.

Recommendation 24: Annually publish anonymised data on outcomes of all incidents of sexual misconduct

Defence should publish data on administrative and disciplinary outcomes for all forms of sexual misconduct incidents. At a minimum, this data should:

- (a) be published on an annual basis, disaggregated by service
- (b) identify the nature and type of all sexual misconduct incidents, including:
 - (i) the nature and type of sexual offences and related offences, including intimate image abuse, stalking and relevant service offences that include sexual misconduct as an element
 - (ii) other forms of sexual misconduct, including sexual harassment and sex discrimination
- (c) include demographic information of victims and perpetrators, including age, rank and gender.

8.7.4 The IGADF Inquiry was only a starting point

370. The IGADF Own Initiative Inquiry into Implementation of Military Justice Arrangements for Sexual Misconduct made some important findings and recommendations. However, the Inquiry was conducted in a very short period of time – the terms of reference were issued on 29 July 2021 and the final report was delivered on 26 November 2021, within just four months.

371. It is therefore unsurprising the Inquiry was unable to resolve all the issues it uncovered.

The IGADF Inquiry had little lived experience evidence or information

372. The IGADF issued the Terms of Reference and Directions for the Inquiry on 29 July 2021, with a draft report due by 15 November 2021.³⁵⁴ On 3 September 2021, Defence published a Defence telegram on its intranet:

It advised of the inquiry and issued an invitation to receive written submissions about the implementation of military justice arrangements for dealing with sexual misconduct in the ADF. The inquiry team was interested in receiving the views of any party involved in managing a complaint of sexual misconduct involving an ADF member, including the perspective of the victim, alleged respondent, and commanders / managers of ADF members.

Submissions were received from 22 persons. The inquiry conducted follow-on interviews over Skype for Business with five of these people. One person consented to be named in the report but the inquiry has chosen not to do so as it may identify a complainant.³⁵⁵

373. Of the submissions received, 15 were from victims.³⁵⁶ The IGADF told us this ‘modest response was expected’:

Given the strong and repetitive focus of Defence on sexual misconduct in the past decade, this modest response was expected. It is often observed by survey and polling organisations that over time, potential respondents tire and lose interest in responding unless they are especially concerned about events in their own lives. Further, of the submissions made, while some related to recent incidents, others were of a more historical nature (before ADF instituted mechanisms such as SeMPRO, for example, and regular incidence surveys).³⁵⁷

374. This certainly has not been our experience, as we have received almost 500 submissions from serving and ex-serving members about their experiences of being subject to sexual misconduct.

375. The inquiry directions to the Assistant IGADF stated it could ‘survey a sample of ADF members’ and ‘conduct focus groups’.³⁵⁸ However, the Inquiry Report stated COVID-19 got in the way:

Prior to commencing the inquiry, scoping and planning was conducted to determine how best to address the terms of reference set out in the inquiry Directions. The Assistant IGADF determined that the inquiry could be conducted by reviewing relevant documentation and interviewing witnesses. The Assistant IGADF initially planned to conduct focus groups and one-on-one interviews in major ADF locations. Unfortunately, due to the imposition of COVID-19 travel restrictions, this could not occur.³⁵⁹

376. The IGADF also acknowledged that while COVID lockdowns ‘inevitably compressed the IGADF Inquiry’s capacity to provide examples of lived experience... this would have enhanced the Report’s impact and may have provided additional insights’.³⁶⁰ We agree.

377. The Inquiry Report stated evidence was obtained by:

reviewing relevant documents, Defence policies, conducting surveys [of Commanding Officers], and interviews. The inquiry also examined case studies of sexual misconduct complaints. These included 30 de-identified ComTrack reports (ten from each Service), four de-identified complaints that had been made to the AHRC and 24 redresses of grievance. The inquiry also conducted interviews as part of the case study into the Air Academy.

In order to objectively determine changes on a range of factors since 2011, the Director People Intelligence and Research was requested to provide data analysis from the Unacceptable Behaviours Survey Reports (2012-2017), the Workplace Behaviours Survey Reports (2018-2021), and relevant YourSay Survey Reports (2012-2021).³⁶¹

The effectiveness of the military justice system in relation to sexual misconduct needs evaluating

378. The IGADF Inquiry found the military justice system was more effective than the civilian system in dealing with sexual misconduct. However, this was based on limited information and analysis. The Inquiry Report stated there was ‘confidence in the military justice system as more effective than the civilian criminal system’. It defined ‘effectiveness’ in terms of ‘speed, fairness, deterrence, outcome’.³⁶²

379. In relation to sexual offences, this conclusion relied on ‘outcomes for the 187 official complaints of sexual offences’ JMPU received in the 2020–21 financial year. This is the same data included in Defence annual reports, discussed in section 8.3.2 and included in Table 8.2. The Inquiry Report stated:

The comparison with outcomes for civilian authorities is instructive; the civilian authorities experience longer delays in resolving complaints than the military justice system, complainants are less likely to withdraw their complaint in the military justice system (11 complaints withdrawn in the civilian system compared with 5 complaints withdrawn in the military justice system) and within the year, the military justice system was more likely to produce an outcome.³⁶³

380. The Inquiry made the following finding:

Finding 9. In comparison, the ADF is quicker to finalise complaints of sexual offences and fewer complaints are withdrawn than in the civilian criminal system.³⁶⁴

381. However, this finding was based on a very limited dataset. As discussed in section 8.3.2, this data only represents a subset of all sexual offences. It does not include non-assaultive sexual offences, or related offences such as stalking and intimate image abuse, which are included in the Defence definition of sexual misconduct. The data is based on a point-in-time assessment for a single year, and only includes outcomes where they occurred within that year. For example, if a report was made in May 2021 and resolved in August 2021, it would not be included in the outcomes reported, as the cut-off date for reporting was July 2021. It cannot therefore be considered a comprehensive dataset.

382. Based on the Inquiry's own definition of 'effectiveness', it appears it did not compare the military justice system deterrent effect against that of the civilian court system. For example, the Inquiry Report is silent on the rate of recidivism, which would be a helpful measure. Nor did the Inquiry Report examine the sentences imposed by the military and civilian justice systems to determine whether they imposed similar punishments for similar sexual offences. This would also be a helpful measure to provide a more robust assessment of the 'fairness' element of effectiveness across both systems, as would a more in-depth analysis of the decisions not to prosecute sexual offences in the military and civilian justice systems.

383. Throughout the course of this Royal Commission, victims (including those part of the Uniform Justice Campaign) have called for sexual offences to be removed from the military justice jurisdiction, and be dealt with solely by the civilian justice system.³⁶⁵

384. We note the IGADF Inquiry found the military justice system was more effective than the criminal justice system in finalising 'complaints' of sexual offences. However, we do not consider that finding to be definitive for a number of reasons, including:

- a lack of submissions from victims of sexual violence in the ADF, and the absence of a survey to ensure their views were heard (beyond the standardised Defence workplace surveys)
- unresolved questions about the JMPU's limited powers to investigate sexual offences compared to civilian police
- the narrow analysis and data sources the inquiry used to determine effectiveness noting the data constraints that existed at the time.

385. In addition, other documents obtained under Notice from Defence referring to research and data further emphasise the need for additional analysis. The Defence People Committee Minutes of June 2021, referred to a briefing from Clinical and Forensic Victimologist Dr Amber McKinley 'on the key findings of the reports of three major ethical research projects completed by the JMPU related to victimological studies of sexual offences across the ADF'.³⁶⁶ The minutes include a research finding that:

47% of ADF victims of sexual offences subject to mandatory reporting under Defence policy elected not to engage with or to withdraw from investigations, **which is more than double the attrition rate seen in the civilian context within Australian society.**³⁶⁷

386. While we have made recommendations to immediately improve how sexual offences are dealt with in the military justice system, implementing those recommendations should not prevent a deeper examination of the ADF's sexual offences jurisdiction.

Other Five Eyes nations have conducted an independent inquiry

387. The US, Canada and the UK have all recently conducted independent inquiries into military sexual violence.

388. In 2021, with reported sexual assault levels increasing, US Secretary of Defense Lloyd Austin established an Independent Review Commission on Sexual Assault in the Military.³⁶⁸ The Commission found the military justice system required commanders to make decisions whether to proceed with criminal sexual assault cases, but they were not equipped to deal with the complexity of sexual assault scenarios.³⁶⁹ Nor was the military justice system ready to respond properly to sexual assault crimes.
389. The Independent Review Commission recommended shifting legal decisions about the prosecution of sexual assault out of the chain of command towards an independent judge advocate to make technical legal decisions.³⁷⁰ Secretary Austin accepted all the Commission's recommendations. The Department of Defense has since worked with Congress to change the law to shift responsibility from military commanders for prosecuting sexual assaults and related crimes. In 2023, each of the services officially opened offices of special trial counsel, so only trained, designated attorneys will decide whether to press sexual assault charges or send a case to trial.³⁷¹
390. In May 2021, the Canadian Government engaged former Supreme Court Justice Louise Arbour to conduct an Independent External Comprehensive Review of policies, procedures, programs, practices and culture within the Department of National Defence and the Canadian Armed Forces (CAF) in relation to the continued presence of harassment and sexual misconduct.³⁷²
391. In what has been described as bold and system-changing, Madame Arbour recommended that *Criminal Code* sexual offences should be entirely removed from the military justice system's jurisdiction.³⁷³ Madame Arbour explains part of the rationale for this, as follows:
- Driven by a desire to improve efficiency, discipline and morale in the CAF the military system obtained concurrent – not exclusive – jurisdiction over sexual offences in 1998. As we stand today, not only has this objective not been met, but if anything, the handling of sexual misconduct by military justice has eroded trust and morale among the organization.³⁷⁴
392. Madame Arbour recommended removing *Criminal Code* sexual offences from CAF's jurisdiction and prosecuting in civilian criminal courts in all cases.³⁷⁵ CAF and Department of National Defence agreed to immediately implement all the recommendations.³⁷⁶
393. In 2017, the Lyons Review into the UK Service Justice System recommended referring all serious offences of a sexual nature in the armed forces to the civilian police. The UK Government rejected the proposal with the then-Defence Secretary stating the existing principle of concurrency between the service justice system and civilian criminal court system should be retained.³⁷⁷
394. Following the Wigston review in 2019, the 2021 UK Parliament's Defence Sub-Committee's report into 'Women in the Armed Forces: From Recruitment to Civilian Life' (the Atherton Report) recommended the Ministry of Defence remove the chain of command entirely from complaints of a sexual nature.³⁷⁸

395. The UK Government responded that it would establish the Defence Serious Crime Unit headed by a new Provost Marshal for Serious Crime. This will enable allegations to be reported independently and investigations to be conducted outside of the single service chain of command.³⁷⁹ It said:

All Service Complaints of a sexual nature will be required to be fully dealt with outside of the direct Chain of Command through single Service central admissibility, with use of independent investigators outside of the direct Chain of Command (for example through the Outsourced Investigation Service), the use of Independent Members at decision and appeal body stages and use of decision makers from outside the direct Chain of Command.³⁸⁰

8.7.5 Independent inquiry needed into sexual violence in the ADF

396. We requested a one-year extension for this Royal Commission from the Australian Government, which it did not grant. While we accept the Government's decision, it has meant there are issues we were unable to fully inquire into – and military sexual violence in the ADF is one of those. It is of critical importance in the overall context of suicide and suicidality, members' health and wellbeing, as well as military capability.

397. If we had been granted further time, we would have been in a position to hear from witnesses in each part of the military and civilian justice systems that are responsible for investigating and responding to sexual violence in the ADF. While we were unable to undertake this task, it is vital that this occurs. Submission authors have highlighted the impact of these systems on their mental health, including risks of suicide and suicidality:

A month into relocating I was sexually assaulted by another Navy member who still remains in the Navy due to poor investigation processes from CIVPOL and JMPU. I now suffer from a few mental health conditions and am unable to work fulltime but have been put in a position and told there are no medics to replace me so I can get some respite and recover.³⁸¹

398. In another submission we were told:

Recently [redacted] ODMP declined to prosecute or seek approval from CDPP for a matter of sexual intercourse without consent and the victim was informed of his decision. The victim was encouraged to report it to the state police. As a result of this decision the victim attempted to take their life.

On this occasion the victim has now reported it to the civilian police who have investigated and are seeking prosecution ... I have seen too many times ODMP refusing to seek approval to prosecute to count, which is disheartening to me and more importantly the victims that have put so much faith in our discipline system only to fail due to someone's reluctance to seek approval.

By not seeking approval as a standard process, I believe Defence are providing an inadequate service and failing those members who choose for Defence to Investigate with possible repercussions of suicide as they have put their faith in Defence and they have not delivered.³⁸²

399. An officer told us:

I personally believe that a case which took four years from reporting to resolution is a failure of the military justice system when noting at trial immediately two charges were plead guilty to by the defendant. I only had the tools to fight for this resolution myself due to understanding the administrative systems and being able to speak directly to high ranking officers regarding my case as an Officer. Whilst I had tried to contact SEMPRO through this process for advice, they were wholly inadequately prepared to manage an incident of this complexity. As a commander, I have found them very useful for discussing policy in this area but from a personal perspective I found them severely lacking.³⁸³

400. We also heard from a victim of sexual assault who emphasised the importance of a robust justice system:

Firstly, when women complain about sexual assault, there is a common theme of victim blaming, unfortunately for some the incident happened when I was in my uniform and no alcohol was involved. As a medic, I have noticed a military culture of if she drinks, she is putting herself at risk rather than he is at fault for taking advantage of her. [Redacted] has reiterated this stereotype in his speech where sexual assault was only due [to] the attributes of a woman. As I mentioned, there was no alcohol involved at the time of my incident so, there was little blame to place on me. Yet, I was seen as someone who broke the morale of the unit and divided, the unit. Such mentalities make it harder to speak out about sexual assault. For some reason, his shame was my cross.

ADFIS did the best they could to investigate the situation, but the truth is they are not detectives and have not been trained to do so. For example, there was evidence that someone saw me fling my hand across to push the accused away but that was never investigated as to why I did that, which could have been held as circumstantial evidence that I was trying to defend myself from someone. Further, the military law is not designed to find justice for the victim, it is designed to sweep things under the carpet. I was contacted a year after the incident, to give testimony in court. Only, because had they not contacted be, it would reflect badly on the legal system. So, a year after I moved on with my life, I had to now relive it.

I won't harp on too much, but the flaws in the ability of the system to investigate and prosecute people accused of assault have led to widespread systemic misogyny where men are aware that they can get away with anything as there is nothing there in the system to hold them accountable. I believe just by having professionally trained military police and a legal system that is dedicated to dealing with such matter would drastically change the way things are now.³⁸⁴

401. We have made recommendations that require immediate implementation. However, there are other issues still requiring examination.

402. The historic and current experiences of victims of all forms of sexual violence in the ADF is horrifying, and has an incalculable impact on both serving and ex-serving members, particularly women. Current, former and future members of the ADF and the Australian public must have confidence in the justice systems established to respond to sexual violence. We recommend an independent inquiry into military sexual violence in the ADF, to report jointly to the Minister for Defence and the Attorney General.
403. We have recommended some minimum requirements for the inquiry's terms of reference, which are summarised below. These are not intended to be exhaustive and the terms of reference should be finalised in consultation with victims of sexual violence in the ADF. Given the very limited representation of victims in the IGADF Own-Initiative Inquiry Report into Implementation of Military Justice Arrangements for Sexual Misconduct, we consider it paramount that their voices are central to this new inquiry.
404. The new inquiry should consider:
405. **The effectiveness of the military justice system compared to the civilian justice system in receiving, investigating and adjudicating on sexual and related offences** – we consider the IGADF Inquiry analysis of the military justice system effectiveness was incomplete. First, the data relied upon to compare the 'speed' at which complaints are resolved in the military and civilian justice systems was limited to one financial year (2020–21), and cannot be considered to be comprehensive. Second, the Inquiry did not look at every aspect of its own definition of effectiveness. It did not examine the punishments applied to comparable offences in each system, nor did it examine recidivism rates. Third, there are unanswered questions about the JMPU's capability to investigate sexual offences compared to civilian police. This includes potential impacts of the JMPU's narrower investigative powers, the decision-making process that governs the referral of matters to civilian police and decisions not to prosecute.
406. **Why victims of sexual violence are taking less formal action** – the IGADF Inquiry highlighted this decrease in actions. It noted this required further investigation, but none has been undertaken. SeMPRO has told us existing anonymous reporting options are sufficient and implementing approaches similar to those in the US are not appropriate, without consulting their counterparts in the US to explore and resolve potential challenges.
407. **Minimal consideration of victims' voices** – the IGADF Inquiry's absence of focus groups or a dedicated survey of members, combined with only receiving 22 submissions, means there is a significant risk it did not sufficiently represent the voices of victims.
408. We acknowledge the frustration and disappointment that many serving and ex-serving members and victims may feel at the prospect of an additional inquiry. We have not taken this decision lightly, and have done so in order to honour the severity and scale of evidence we have heard during the course of this Royal Commission. We do not want any of the victims who have courageously shared their stories with us to be re-traumatised by a further inquiry. The independent inquiry should have regard to all lived-experience testimony, statements, exhibits and published submissions made to this Royal Commission as they relate to sexual violence in the ADF.

Recommendation 25: Conduct a formal inquiry into military sexual violence in the Australian Defence Force

The Australian Government should commission an external, independent, expert inquiry into military sexual violence in the Australian Defence Force (ADF), with a report that includes recommendations provided to the Minister for Defence, the Minister for Defence Personnel and the Attorney General, and made public.

The terms of reference for this inquiry should be developed in consultation with victims of sexual violence in the ADF (serving and ex-serving), and at a minimum should include:

- (a) the effectiveness of the military justice system compared to the civilian justice system in receiving, investigating and adjudicating on sexual and related offences. This should include an examination of the Joint Military Police Unit's investigative powers and capability to conduct sexual offence investigations; the referral of matters to civilian police; any barriers faced by civilian police investigating sexual offences on ADF bases; sentencing outcomes; recidivism rates; decisions not to prosecute and conviction rates
- (b) the underlying reasons for the reduction in actions (including making a report, and agreeing to reported matters being investigated) taken by victims of sexual violence, including the role of alcohol and other barriers, and the adequacy of ADF policies in addressing these
- (c) the effectiveness of anonymous reporting options including awareness, uptake and impact compared to alternative approaches (including but not limited to the approach taken in the United States).

The inquiry should have regard to all lived-experience testimony, statements, exhibits and published submissions made to this Royal Commission that are related to sexual violence in the ADF.

Annexure 8.1 Defence Implementation of IGADF Inquiry

IGADF Recommendation ³⁸⁵		Defence Response	Analysis of those assisting the Commissioners as at 12 March 2024
1.	Defence identify the objectives of its sexual misconduct policy and assign suitable targets within given timeframes. The objectives and targets should be communicated effectively and consistently across the Defence enterprise and linked with Defence's values.	<p>Recommendation will be implemented in full.</p> <p>The Defence Sexual Misconduct Prevention and Response Strategy will articulate Defence's strategic objectives in relation to sexual misconduct.</p> <p>Scheduled for completion by Q4, 2023.³⁸⁶</p>	<p>The draft Sexual Misconduct Prevention and Response Strategy does not articulate Defence's strategic objectives in relation to sexual misconduct, but includes the following 'key messages':</p> <ol style="list-style-type: none"> 1. Defence does not tolerate sexual misconduct and is committed strongly to preventing sexual misconduct from occurring. 2. Defence recognises that sexual misconduct impacts a range of people in a number of ways. 3. Defence considers the welfare of any person subjected to or impacted by a sexual misconduct incident to be central to our response processes. 4. All allegations of sexual misconduct are managed promptly and sensitively in Defence.³⁸⁷ <p>Some but not all of the above could be considered objectives. For example, Key Messages 1 and 4 could be considered objectives, as metrics could be developed to measure the extent to which they are achieved.</p> <p>The draft Sexual Misconduct Prevention and Response Strategy does not contain any targets or associated timeframes. It does contain 'indicators of success', but these are qualitative statements (such as 'Recruitment, promotion and performance management processes contribute to a safe, respectful, and inclusive workplace') and there is no indication of which 'indicators of success' are currently present or which require additional work to be achieved.³⁸⁸</p> <p>In oral evidence in Hearing Block 12, SeMPRO told the Royal Commission that the Sexual Misconduct Prevention and Response Strategy is due to be endorsed in May 2024, and released in June–July 2024.³⁸⁹</p> <p>Conclusion: IGADF Recommendation has not been implemented, and will not be if the draft Sexual Misconduct Prevention and Response Strategy remains in its current form.</p>

IGADF Recommendation ³⁸⁵	Defence Response	Analysis of those assisting the Commissioners as at 12 March 2024
2. Defence should promote its sexual misconduct policy as an integrated system, based on Defence values and supporting safety and capability.	<p>Recommendation will be implemented in full.</p> <p>Action on this recommendation will be enhanced through the development and release of the Defence Sexual Misconduct Prevention and Response Strategy.³⁹⁰</p>	<p>In response to compulsory notice, Defence have told the Commission that there has been the following action to date:</p> <ul style="list-style-type: none"> • CARM Chapter 9 updates and accompanying interactive portal • Sexual misconduct education became mandatory from January 2023 • Defence's Statement on Sexual Misconduct in the ADF was released in July 2022.³⁹¹ <p>The draft Sexual Misconduct Prevention and Response Strategy states it 'is based on Defence values and supports our safety and capability goals', and recognises the negative impact of sexual misconduct on capability.³⁹²</p> <p>Conclusion: Recommendation has been implemented.</p>
3. The Mandatory Workplace Behaviour Awareness Program should be updated annually and include more information about consent.	<p>Recommendation will be implemented in a modified form:</p> <p>Mandatory Workplace Behaviour Awareness and Sexual Misconduct Education Packages should be reviewed every 24 months (or more frequently as required) and include more information about consent.³⁹³</p>	<p>In response to a compulsory notice, Defence told the Commission that Defence's mandatory sexual misconduct education packages (Foundations of Knowledge and Application of Knowledge) include the topic of consent. A standard review cycle of 24 months has been set, and 'out of cycle updates can still be made in response to legislative or policy changes'.³⁹⁴</p> <p>Conclusion: Modified recommendation has been implemented.</p>

IGADF Recommendation ³⁸⁵		Defence Response	Analysis of those assisting the Commissioners as at 12 March 2024
4.	Defence should provide clear guidance on the level of information to victims on what action has been taken against a respondent in a sexual misconduct incident.	Recommendation will be implemented in full. ³⁹⁵	<p>CARM Chapter 4, 'Notification of Outcomes', was released in February 2024. It states that:</p> <p>The complainant is to be notified of the specific findings and action taken in relation to the outcome of their complaint, unless there is a legal reason not to. Where a legal reason exists not to inform a complainant of specific findings and actions in relation to their complaint, the complainant should be advised of that legal reason.³⁹⁶</p> <p>Complainants are 'usually to be informed of':</p> <ul style="list-style-type: none"> • Timeframes on how the complaint will be handled, including when and how updates will be provided • The findings in relation to the complaint • Any action that was taken against an individual as a result of the findings, including the type of action taken (e.g. formal warning imposed) • Any immediate action or recommendation to another authority to improve policy, process or training as a result of the complaint.³⁹⁷ <p>Conclusion: Recommendation has been implemented.</p>
5.	The ADF should consider adopting the US program CATCH, or adopt the US SAPRO's greater use of restricted reports to encourage official reporting.	Recommendation will be implemented in full. ³⁹⁸	<p>Defence has determined it will not be adopting the US program CATCH, and will not be adopting the US SAPRO's greater use of restricted reports.</p> <p>SeMPRO did not directly consult with SAPRO when considering this recommendation.³⁹⁹</p> <p>Conclusion: Recommendation has been implemented however no changes have been made.</p>

IGADF Recommendation ³⁸⁵	Defence Response	Analysis of those assisting the Commissioners as at 12 March 2024
<p>6. Sexual misconduct management must provide for a greater focus on perpetrators and prevention. Defence data and research capability is well able to assist with this task.</p>	<p>Recommendations 6 and 7 will be combined - Sexual misconduct management in Defence provide for a greater focus on developing targeted prevention and behaviour change programs.</p>	<p>In response to a compulsory notice, Defence told the Royal Commission that research related to sexual misconduct was already underway which:</p> <p>would better inform understanding of offending and perpetrators. Research has commenced, with reports being progressively delivered in 2022-23 into topics including new relationship definitions; technology facilitated sexual violence; sexual offence misconceptions; temporal aspects of sexual offending; and recidivist offenders.⁴⁰⁰</p>
<p>7. Prevention should include a focus on behaviour change programs which are appropriately developed and targeted for perpetrators and based on Defence research.</p>	<p>Scheduled to be implemented by Q2, 2024.⁴⁰¹</p>	<p>Defence told the Royal Commission in response to a separate compulsory notice that:</p> <p>Defence does not provide and is not developing programs specifically targeted at perpetrators or potential perpetrators of sexual misconduct, (i.e. individuals who have had an incident of sexual misconduct substantiated against them or who were involved in an investigation involving such conduct against them).⁴⁰²</p> <p>Defence also informed the Royal Commission in response to a compulsory notice that 'in the event of alleged or substantiated sexual misconduct individuals are referred back to the Foundation of Knowledge training'⁴⁰³ but also informed us that 'this course is not specifically aimed at perpetrators'.⁴⁰⁴</p> <p>In oral evidence during Hearing Block 12, SeMPRO was unable to answer how sexual misconduct management will include a greater focus on targeted behaviour change programs.⁴⁰⁵</p> <p>Conclusion: Combined recommendation has not been implemented.</p>

IGADF Recommendation ³⁸⁵		Defence Response	Analysis of those assisting the Commissioners as at 12 March 2024
8.	Command accountability for fairly managing respondents and complainants could be reported on in annual performance appraisals.	Recommendation will be implemented in full. ⁴⁰⁶	<p>In response to a compulsory notice, Defence 'identified that existing structures and ongoing work were fully responsive to this recommendation', citing the following examples:</p> <ul style="list-style-type: none"> • CARM details the expectations and requirements for all Defence personnel in the management of unacceptable behaviour • Current performance appraisal and performance management arrangements meet the 'command accountability' intent of the recommendation <p>The 'CDF specifically noted that he agreed that where management has been consistently exemplary or specifically deficient, it should be commented upon in the narrative area of the performance appraisal report in a generalised form that does not breach confidentiality, as would other notable elements of performance. Specificity of detail should be noted in the Defence Incident Record. The requirement for Senior Assessing and Assessing Officers to incorporate the narrative is communicated through Service Senior Leadership to personnel management agencies and Commands.'⁴⁰⁷</p> <p>Conclusion: Defence considered no changes were required to implement this recommendation.</p>
9.	Victims of sexual misconduct should be provided written advice about their options in reporting a complaint and the possible outcomes that may be available.	<p>Recommendation will be implemented in a modified form:</p> <p><u>Defence will consider</u> the provision of written advice to complainants and respondents in sexual misconduct incidents to inform them about reporting and support options and the possible outcomes that may occur.⁴⁰⁸</p>	<p>In response to a compulsory notice, Defence told the Royal Commission:</p> <ul style="list-style-type: none"> • SeMPRO clients are already provided 'with verbal advice and a follow-up email with a summary of options (for those who choose not to remain anonymous)' • Complainants can follow process maps in the CARM Chapter 9 interactive framework 'to determine their various reporting options and potential outcomes'⁴⁰⁹ <p>Factsheets on reporting options and potential outcomes were being considered for complainants and respondents.⁴¹⁰ The Commission received a copy of these factsheets in response to compulsory notice:</p> <ul style="list-style-type: none"> • JMPU factsheet on reporting and support options in response to sexual offences in the ADF⁴¹¹ • SeMPRO Factsheet for commanders and managers.⁴¹² <p>Neither of these factsheets provide information for victims of sexual misconduct about the possible outcomes that may be available if they report a complaint.</p> <p>Conclusion: Modified recommendation has been implemented however no changes have been made.</p>

IGADF Recommendation ³⁸⁵	Defence Response	Analysis of those assisting the Commissioners as at 12 March 2024
<p>10. The ADF should report, in a de-identified manner, the disciplinary and administrative sanctions outcomes of substantiated sexual misconduct complaints. This information should be updated regularly and incorporated into annual mandatory awareness training.</p>	<p>Recommendation will be implemented in a modified form:</p> <p>The ADF should report, in a de-identified manner, the disciplinary and administrative sanctions / outcomes of substantiated sexual misconduct complaints. This information should be updated regularly and <u>consideration</u> given to <u>incorporating</u> appropriate content into annual mandatory awareness training.⁴¹³</p>	<p>In response to a compulsory notice, Defence told the Royal Commission: There is already publicly available content based on the Sexual Assault Action Tracking process which tracks 'the policing and legal outcomes of a matter and then matches it with the disciplinary and administrative action taken by Defence in response'.⁴¹⁴</p> <p>The 2022-23 Defence Annual Report includes some of this data but it only captures outcomes for sexual assault complaints reported in the same financial year.⁴¹⁵ This makes it difficult to assess how many complaints actually proceed to trial and/or result in administrative and disciplinary action, as there is no roll-over reporting from one year to the next. It also only states whether or not there was a guilty outcome and whether an administrative sanction was applied, it does not specify the nature of the sanction (e.g. dismissal, formal warning, reduction in rank etc) in line with the recommendation.</p> <p>Data for outcomes related to sexual harassment and sex discrimination is reliant on the CASE management system.⁴¹⁶ However, Defence was silent on whether outcomes data would be published on a de-identified basis once CASE was operational.</p> <p>SeMPRO was concerned that 'it would be difficult to completely de-identify reporting given Defence's comparatively small dataset',⁴¹⁷ however Defence did not specify what the comparator was.</p> <p>There were also concerns that publishing outcomes 'could send an unintended message that a punishment was unlikely', however this implies that substantiated sexual misconduct complaints do not attract punishment.⁴¹⁸</p> <p>In oral evidence in Hearing Block 12, Ms Urquhart, SeMPRO confirmed that annual mandatory awareness training does not incorporate the disciplinary and administrative sanction outcomes of substantiated sexual misconduct complaints.⁴¹⁹</p> <p>Conclusion: Modified recommendation has not been implemented and no further action is planned.</p>

IGADF Recommendation ³⁸⁵	Defence Response	Analysis of those assisting the Commissioners as at 12 March 2024
<p>11. SeMPRO should annually report on restricted disclosures made to it and ensure any trends and significant changes are identified.</p>	<p>Recommendation will be implemented in full.⁴²⁰</p>	<p>In response to a compulsory notice, Defence told the Royal Commission: 'Defence has determined that existing structures and processes implemented the substance of the recommendation to the extent it can be implemented by Defence'.⁴²¹</p> <p><i>Internal Reporting</i></p> <p>'Restricted disclosure data is already collected by SeMPRO and reported in a de-identified manner to HPC. The identification of trends could be conducted as part of the broader analysis of sexual misconduct data to be actioned under other recommendations, although it was agreed that the data sets are small so the feasibility of identifying actionable trends and/or themes would be limited'.⁴²²</p> <p><i>External Reporting</i></p> <p>Defence did not agree to this recommendation 'It was agreed that external reporting of very small numbers could pose an actual or perceived risk to these clients' confidentiality and therefore act as a barrier to service use. Additionally, it was further agreed that considering 'Restricted Disclosure' data in isolation does not consider how it interacts with the broader supporting and reporting systems available in Defence'.⁴²³</p> <p>Conclusion: Defence considered no changes were required to implement this recommendation.</p>
<p>12. The IGADF should work with the proposed new SeMPRO and Provost Marshal forum to both monitor its development, so that it can be included in the review of the Defence Data Division in 2023, and assist in ensuring the proposed pilot project is carried out and evaluated in a timely way.</p>	<p>This recommendation was directed to the IGADF. Noting the statutory independence of the IGADF, the recommendation is noted by Defence only, as the scope of actions to monitor and assist will need to be determined by the IGADF.⁴²⁴</p>	<p>In response to compulsory notice, Defence told the Royal Commission the Director of Inquiries and Investigations, IGADF attended the first meeting of the forum in April 2023.⁴²⁵</p> <p>The forum did not progress to the point of data compilation⁴²⁶, and is therefore not considered to have been carried out or evaluated in a timely way.</p> <p>Conclusion: The IGADF was involved in the forum, however the intent of this recommendation was not achieved.</p>

IGADF Recommendation ³⁸⁵	Defence Response	Analysis of those assisting the Commissioners as at 12 March 2024
<p>13. That the Defence People Committee commission work into the development of suitable metrics to measure the impact of the policy on ADF personnel safety and capability, as well as some refining of the existing measures applied to prevalence, occurrence and commitment.</p>	<p>Recommendation will be implemented in full.</p> <p>Recommendation is scheduled to be implemented by Q2, 2024.⁴²⁷</p>	<p>In response to compulsory notice, Defence told the Royal Commission: The intent of this recommendation will 'be best achieved employing an integrated data system'.⁴²⁸</p> <p>Defence told the Royal Commission in response to a separate compulsory notice that 'there is currently no available or feasible mechanism to centralise relevant data as there are multiple data sources and there is a challenge regarding the consistency of definitions of sexual misconduct used across disparate business areas'.⁴²⁹</p> <p>Defence also told the Royal Commission that 'Development of impact metrics is fundamentally linked to the objectives of Recommendation 1. Measures of performance and effectiveness will need to be defined to realise measures of success (i.e. achievement of strategic objectives)'.⁴³⁰</p> <p>The draft Defence Sexual Misconduct Prevention and Response Strategy does not articulate strategic objectives, and does not include any quantifiable metrics to measure the 'indicators of success'.⁴³¹</p> <p>Defence told the Royal Commission the following work remains to be done to implement the recommendation:⁴³²</p> <p>The requirement for Defence to resource genuine evaluation and sophisticated data analysis was agreed. Under oversight of the Defence People Committee, work to identify suitable metrics, integrating the findings of research into sexual misconduct will be conducted. Integration with the Defence White Paper Personnel Initiative-funded research will mean that a full range of metrics cannot be confirmed until after the final report is submitted in Q4 2023.</p> <p>Conclusion: In order for this recommendation to be implemented, Defence needs to define objectives for the draft Defence Sexual Misconduct Prevention and Response Strategy, agree on quantitative metrics to measure their success, and develop an integrated dataset for sexual misconduct incidents.</p>

Annexure 8.2 Suspension from duty and approaches in other public service organisations

Suspension from duty

409. In the ADF, suspension from duty can occur in the following circumstances:

- A member can be suspended from duty under the *Defence Force Discipline Act 1982* (Cth), where they:
 - Are suspected on reasonable grounds to have committed an offence and an investigation is to commence (suspension with pay only)
 - Have been charged with a service offence, civil court offence or overseas offence (suspension with or without pay)
 - Have been convicted of a service offence, civil court offence or overseas offence and a decision is pending regarding termination of service (suspension with or without pay).⁴³³
- A member can be suspended from duty (with or without pay) under the *Defence Force Regulation 2016*, where they:
 - Have been issued a proposed termination notice, or have received a decision that their service will be terminated
 - Have tested positive to a prohibited substance.⁴³⁴

410. If the legislative criteria are not met (e.g. if the misconduct does not constitute an offence), commanders can suspend members from duty (with pay only) using the command power. The Army Directive provides that:

- Command power suspensions should only be used as a short to medium term measure, in the context of managing members and resources until the completion of some other finite and conclusive process, and must not be punitive.
- The fact that a member may no longer be required to perform specific duties or be subject to particular hardships may result in the loss of certain allowances or benefits. Before seeking to stop any allowances or benefits, the member must be provided with procedural fairness by issuing a notice to show cause why allowances and/or benefits should not cease, and afforded the opportunity to respond.⁴³⁵

Managing victim safety and procedural fairness in other public service organisations

Queensland Public Service

411. Queensland Public Service policy provides that a manager can suspend an employee if 'it's unsafe or a risk to the business for them to remain in the workplace' while concerns about their conduct are being reviewed. Suspension is to be considered in a range of circumstances, including if the employee's alleged conduct raises concerns about work health and safety risks to others. Suspension may be appropriate if the impacts cannot be managed and the employee's alleged conduct involves physical or sexual conduct or serious verbal abuse towards clients or co-workers.⁴³⁶
412. The policy provides that a manager should consider suspension with pay where they have:
- commenced an investigation into serious allegations against the employee
 - received serious allegations of misconduct including sexual harassment, fraud or assault
 - concerns about the safety of the work environment while they address the matter
 - concerns about the employee tampering with evidence relevant to the allegation
 - reasonable belief that the employee's poor behaviour is due to a medical condition
 - reasonable belief that, if proven, the conduct would lead to a serious disciplinary penalty.
413. Suspensions without pay are limited to the following circumstances:
- External factors outside the agency's control preventing the agency from finalising the disciplinary matter for an extended period, for example criminal charges, and the discipline process is pending the outcome of these charges.
 - Circumstances that would make it fair and reasonable to suspend the employee without pay. This must be considered against the financial impact on the employee and the public interest of an employee remaining on suspension with remuneration.

Australian Public Service

414. Unlike Queensland, the Australian Public Service policy does not specifically consider instances of sexual misconduct. Similar considerations apply (for example, seriousness of the conduct, the need to ensure no implication of guilt), as well as similar avenues for action (for example, reassignment of duties / work location, suspension from duty). Guidance on the circumstances for suspension from duty is also more limited, but includes considering if it is in the public's or agency's interests where continued presence in the workplace may pose risks to the safety and wellbeing of other employees.⁴³⁷

Victoria Police

415. Victoria Police commissioned the Victorian Equal Opportunity and Human Rights Commission to undertake an independent review to examine sex discrimination and sexual harassment, including predatory behaviour, happening within the organisation. The review concluded in 2015, and Victoria Police has undertaken a range of reforms in response, including a dedicated policy on managing sexual misconduct investigations.
416. If a Victorian Police employee is subject to a sexual misconduct report, one of the following interim actions must be taken:
- Employee is directed to take leave
 - Employee is transferred to another work location or alternative duties
 - Employee is suspended (with or without pay).
417. A range of factors are taken into account to inform the decision about which interim action is taken, including the seriousness of the allegations, the risk to the victim and alleged perpetrator, and the broader workplace.⁴³⁸

Annexure 8.3 Sexual and related offence provisions

Crimes Act 1900 (ACT)

Part 3 Sexual Offences

51 Sexual assault in the first degree

52 Sexual assault in the second degree

53 Sexual assault in the third degree

54 Sexual intercourse without consent

55 Sexual intercourse with young person

55A Sexual intercourse with young person under special care

56 Persistent sexual abuse of child or young person under special care

57 Act of indecency in the first degree

58 Act of indecency in the second degree

59 Act of indecency in the third degree

60 Act of indecency without consent

61 Acts of indecency with young people

61A Act of indecency with young person under special care

61B Intimate observations or capturing visual data etc

62 Incest and similar offences

63 Abduction

63A Bestiality

64 Using child for production of child exploitation material etc

64A Trading in child exploitation material

65 Possessing child exploitation material

66 Grooming and depraving young people

66AA Failure to report child sexual offence

66AB Making false report about child sexual offence

66A Failure by person in authority to protect child or young person from sexual offence

Part 3A Intimate image abuse

72C Non-consensual distribution of intimate images

72D Distribution of intimate image of young person

72E Threaten to capture or distribute intimate images

Criminal Code Act 1995 (Cth)

Division 272—Child sex offences outside Australia

272.8 Sexual intercourse with child outside Australia

272.9 Sexual activity (other than sexual intercourse) with child outside Australia

272.10 Aggravated offence—child with mental impairment or under care, supervision or authority of defendant

272.11 Persistent sexual abuse of child outside Australia

272.12 Sexual intercourse with young person outside Australia—defendant in position of trust or authority

272.13 Sexual activity (other than sexual intercourse) with young person outside Australia—defendant in position of trust or authority

272.14 Procuring child to engage in sexual activity outside Australia

272.15 ‘Grooming’ child to engage in sexual activity outside Australia.

Endnotes

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- 2 Transcript, CB1, Hearing Block 4, 5 April 2022, p 25-2249 [5–13].
- 3 Gabrielle Karas on behalf of Mary Ross, Submission, ANON-Z1E7-QWXW-X, p [3].
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- 13 Transcript, Fleur James, Hearing Block 12, 12 March 2024, p 90-9018 [28–35].
- 14 Transcript, David Johnston, Hearing Block 12, 4 March 2024, p 86-8538 [20–38].
- 15 Transcript, Alex Shehadie, Hearing Block 1, 3 December 2021, p 5-439 [40–46].
- 16 Transcript, Nikki Coleman, Hearing Block 11, 29 August 2023, p 77-7438 [17–27].
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- 18 Ross Dunn, Submission, ANON-Z1E7-QWV5-T, p [9].
- 19 Name withheld, Submission, ANON-Z1E7-QWX4-U, p [2].
- 20 Name withheld, Submission, ANON-Z1E7-Q9CU-9.
- 21 Name withheld, Submission, ANON-Z1E7-Q81R-K.
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- 23 Sarah Boshammer, Submission, ANON-Z1E7-Q82A-3.
- 24 Exhibit G-01.001, Chrystina Stanford, CEO, Canberra Rape Crisis Centre, Response to Notice to Give, NTG-CSH-001, DVS.2222.0001.0314 at 0323.
- 25 Transcript, Megan MacKenzie, Hearing Block 3, 8 March 2022, pp 17-1501 [33]–2-1502 [10]; R Kimerling and others, 'Military sexual trauma and suicide mortality', *American Journal of Preventive Medicine*, vol 50, 6, 2016.
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9 Unacceptable behaviour and complaints management

Summary

Keeping members safe and preventing them from experiencing unacceptable behaviour has been an ongoing challenge for the Australian Defence Force (ADF). Defence workforces can be challenging environments; ADF members can spend nearly 24 hours each day in close proximity to each other, living, working and even sleeping side by side.

The ADF uses voluntary surveys to identify how many members have experienced unacceptable behaviour. As recently as 2022, 33% of male and 52% of female permanent serving members who responded to a survey reported having experienced unacceptable behaviour in the previous 12 months.¹

Particular locations and cohorts of members are especially likely to have experienced unacceptable behaviour. For example, unacceptable behaviour tends to be prevalent in some training institutions, certain units, 'bad bases' and groups with toxic subcultures. Women and members who are perceived as 'different' are more likely to experience unacceptable behaviour. To address this, there needs to be a cultural shift through all services and all ranks.

This chapter explores the prevalence and consequences of unacceptable behaviour, paying attention to cultural influences within the ADF, including the influence of alcohol.

The ADF has yet to fully address the structural and cultural barriers to preventing and managing unacceptable behaviour. These include the role of leaders and the pressing need for complaints mechanisms outside the chain of command.

While training to identify and prevent unacceptable behaviour is provided from the commencement of service, this training has not yet improved the management of complaints for many complainants nor the support provided to members who have experienced unacceptable behaviour.

Many previous reviews and inquiries have attempted to rebuild and reshape Defence's internal complaints mechanisms, making recommendations for improvement. While Defence has attempted to build safe and effective complaints mechanisms throughout much of its history, we have yet to see an effective mechanism that prevents member suffering.

Sadly, a significant number of current and former serving members have been subjected to harassment, violence and abuse. This has had a negative effect on their mental health.

Defence has an imperative to maintain a deployable workforce. To do this, it must provide its members with a working environment that supports their physical and psychological wellbeing, while recognising the inherent dangers of service life. The current prevalence of unacceptable behaviour in the ADF is not compatible with maximised operational potential. Without improvements in the handling of unacceptable behaviour, including a more effective complaints system, Defence will increasingly struggle to fulfil its mandate.

9.1 Introduction

1. Institutional and interpersonal abuse has cast a long shadow over the history of the Australian Defence Force (ADF). During our inquiry, we have heard and read thousands of accounts of current and former serving members whose lives have been impacted and often devastated by the scourge of harassment, violence, abuse and misconduct.²
2. We have heard from military academics and historians that the ADF, like all Five Eyes nations, has faced institutional and interpersonal violence 'since its inception'.³ By one count, there have been 35 separate inquiries into military justice and culture in the ADF over the last half-century.⁴ According to a 2020 academic article, 'nearly a dozen' of these inquiries 'found evidence of cultural problems and systemic abusive behaviour'.⁵
3. Our interim report summarised some of the key inquiries into ADF culture and 'unacceptable behaviour' since the so-called 'Skype incident' at the Australian Defence Force Academy (ADFA) in April 2011.⁶ This incident and the inquiries that followed it helped catalyse Defence's cultural reform agenda over the past 13 or so years.⁷ This is explored in further detail in Chapter 7, Culture and leadership.
4. Far too many serving members continue to experience harassment, violence, abuse and misconduct. Members may also face significant barriers to reporting, and the poor handling of complaints can compound trauma and the related ill effects of these experiences. As one research paper funded by the Royal Commission concluded, 'military institutional abuse is not simply interpersonal. It is a systematic enduring institutional disposition'.⁸
5. We acknowledge the deep frustration of many serving and former serving members who have watched many inquiries come and go. Meaningful progress – if any has been made at all – has felt far too slow. Indeed, the then Chief of the Defence Force acknowledged that incidents of unacceptable behaviour have been on the rise since 2016.⁹

6. One study, which focused on sexual violence in the ADF, described a frustrating pattern of:

(1) a high-profile case being followed by, (2) public declarations of zero tolerance by military and/or government officials, and (3) a call for a review, investigation, or public inquiry. We also find that often absent from this reactive cycle are any lasting policy changes that make a long-term impact on rates of everyday sexual violence in the military.¹⁰
7. Pursuing the ideal of preventing harassment, violence, abuse and misconduct in the ADF, and effectively managing it when it does occur, is an immense challenge. Behaviour of this kind should not be considered an inevitability of service life. For the ADF to maintain operational readiness, it needs to have a workforce that wishes to remain within the ADF. It needs to be an employer of choice where serving personnel can trust their colleagues and leaders, and physical and psychological workplace safety are rigorously upheld.
8. Experiencing unacceptable behaviour negatively affects member wellbeing. Those on the receiving end of these behaviours often experience poor outcomes, including involuntary medical separation, and separation that is voluntary but is accompanied by a feeling of being betrayed by the organisation. The loss of members through the direct and indirect consequences of unacceptable behaviour contributes to the hollowing out of the workforce, which is discussed further in Chapter 6, Retention issues and voluntary separation.
9. Those who perpetrate these behaviours also frequently experience negative outcomes, including involuntary separation for the reason of 'retention-not-in-service-interest' when their behaviours are called out, which is examined in Chapter 10, The ADF military justice system.
10. It should also be noted that *all* those involved in incidents of unacceptable behaviour are at risk of moral injury, be it because they have acted in ways that transgress their moral code, have been the victims of actions that transgress their moral code, or have been bystanders and have chosen not to speak up or have not felt able to speak up. Moral distress and moral injury, which are discussed in depth in Chapter 21, Moral injury, are not yet well understood but are known to contribute to psychological distress that is itself a significant risk factor for suicide and suicidality.¹¹
11. The nature of service life, military culture and military organisational structures are such that serving members on the receiving end of unacceptable behaviour find that their choices and actions are circumscribed by context. Aspects of that context include military tradition, their trained responses, norms of behaviour, and the written and unwritten rules of military organisational culture. Members who witness or experience unacceptable behaviour across a wide spectrum of perceived severity face very particular challenges, barriers and obstacles in deciding how to respond.

12. In this chapter, we identify the challenges, barriers and obstacles faced by members who have experienced unacceptable behaviour. We also identify those cohorts who, because of some of the undesirable aspects of military culture, are most likely to be subjected to unacceptable behaviour. We discuss the reasons why trust in the complaints process is low and make the case that meaningful progress towards the prevention of harassment, violence, abuse and misconduct in the ADF is impossible without genuine cultural change at all levels of the organisation.

9.2 Unacceptable behaviour in the ADF

13. Many and varied sources of evidence and testimony that have come to light in our inquiry have shown that ADF members' experience of unacceptable behaviour during their service life is a risk factor for suicide and suicidality.¹² We have also found that the mismanagement, or the perception of the mismanagement, of complaints of unacceptable behaviour is a risk factor for suicide and suicidality.¹³ As Air Commodore Lara Gunn CSM stated:

It is my observation that serious abuse suffered by ADF members in service, including the mis-management of that abuse, can be a contributing risk factor in deaths by suicide, attempted suicide and poor mental health.¹⁴

14. For these reasons, we need to understand:
- who in the ADF believes they have the right to harass, abuse and commit violence against others
 - which cohorts continue to experience unacceptable behaviour despite efforts at cultural reform
 - why unacceptable behaviour continues to occur
 - what can be done to reduce and ultimately prevent the occurrence of unacceptable behaviour.
15. We also need to understand how to support meaningfully and truly those who experience these behaviours. If Defence understands these issues and genuinely addresses them, we believe it will reduce the suicide and suicidality risk to serving and ex-serving members. However, more than that, it is the just and right thing to do.
16. While experts who have appeared before this Royal Commission have pointed to deficiencies in using the term 'unacceptable behaviour' (as discussed in Chapter 8, Military sexual violence, and Chapter 10), in the interests of clarity, we have elected to use the term as defined in the ADF's Complaints and Alternative Resolution Manual (CARM).¹⁵ The CARM, which is more than 200 pages long, provides information about employment or service complaints and alternative resolution processes in Defence for all personnel.¹⁶

9.2.1 Defining unacceptable behaviour

17. The term 'military institutional abuse' is used elsewhere to describe certain kinds of unacceptable behaviour, such as bullying, sexual assault, sexual harassment, hazing and bastardisation, as well as other forms of abuse, such as administrative violence.¹⁷ The term 'administrative violence' describes 'when command discretion is used to target, humiliate, punish or harass subordinates'.¹⁸
18. Defence has not adopted the terminology of military institutional abuse in its definition of 'unacceptable behaviour'. For clarity, we have chosen to adopt Defence's terminology in this chapter. However, we do not consider that the term 'unacceptable behaviour' adequately captures the full extent or nature of the abuse experienced by some members of the ADF.
19. The CARM defines unacceptable behaviour as:

unreasonable conduct at work or in any situation that may be connected to Defence that is offensive, belittling, abusive or threatening to another person or adverse to morale, discipline or workplace cohesion. This includes unlawful discrimination and harassment.¹⁹
20. The CARM states that all ADF members have a responsibility to uphold Defence values and behaviours, to not engage in unacceptable behaviour, and to take steps in the workplace to prevent and respond to unacceptable behaviour.²⁰
21. Chapter 3 of the CARM provides the following non-exhaustive list (and definitions) of conduct that is considered 'unacceptable behaviour':²¹
 - (1) Harassment:

unwanted or unwelcome behaviour that a reasonable person, having regard to all the circumstances, would consider offensive, insulting, humiliating or intimidating²²
 - (2) Workplace bullying:

a persistent, unreasonable pattern of behaviour directed towards a person or group of persons, which may create a risk to health and safety, including a risk to the emotional, mental or physical health of the person(s) in the workplace²³
 - (3) Any form of sexual misconduct:

used to cover the full spectrum of inappropriate behaviours of a sexual nature, from unacceptable behaviours that are visible and non-criminal, through to criminal behaviours²⁴
 - (4) Discrimination:

any distinction, exclusion or preference that has the effect of nullifying or impairing equality of opportunity or treatment in employment or occupation²⁵

(5) Abuse of power:

attributed to rank or position to harass, discriminate or bully a subordinate is unacceptable, unethical and in some situations can constitute criminal behaviour²⁶

(6) Conflict of interest and inappropriate workplace relationships:

a relationship that involves, or gives the appearance of involving, partiality, preferential treatment or improper use of rank or position; that is inappropriate in the workplace, irrespective of the employment type of the people involved²⁷

(7) Violent behaviour:

the intentional use of physical force, threatened or actual, against oneself, another person, or against a group or community or property which either results in or has a high likelihood of resulting in injury, death, or psychological harm.²⁸

22. We acknowledge the experiences of serving and ex-serving members who have suffered forms of harm that may not be adequately captured by the CARM definitions, including those who have been subjected to extreme endurance training, reputational damage, sabotage and administrative violence.²⁹ Some of these experiences are examined in Chapter 10. The analysis that forms the remainder of the chapter, including our recommendations, should also be applied to these practices and behaviours.

9.2.2 Prevalence of unacceptable behaviour

23. One way that the ADF collects information about the prevalence and types of unacceptable behaviour is through internal surveys. These surveys allow serving members to disclose their experiences anonymously.
24. It is not mandatory to complete the Workplace Behaviour Survey, and the response rates to this survey varies. However, an analysis of Workplace Behaviour Survey data from 2018 until the first quarter of 2023 shows that despite a range of initiatives to address unacceptable behaviour, rates have remained largely stable across the ADF since 2018.³⁰
25. For example, in 2022, 38% of permanent ADF members who participated in the survey reported experiencing some form of unacceptable behaviour in the previous 12 months, with female participants experiencing a higher rate of unacceptable behaviour than male participants. In 2022, 33% of male permanent ADF members who participated reported experiencing unacceptable behaviour in the previous 12 months, compared to 52% of female permanent ADF member participants.
26. The survey results indicate that permanent serving Navy members (both males and females) experienced the highest rates of unacceptable behaviour across the three services. In 2022, close to 60% of female respondents in the Navy reported experiencing unacceptable behaviour in the previous 12 months. This figure was consistent with those reported in the surveys between 2018 and March 2023.³¹ We explore this data further in Appendix L, Defence survey data.

27. Survey data shows that permanent serving participants aged 17 to 30 experienced unacceptable behaviour at a higher rate than other age groups. This trend was observed in both males and females. The data shows that across all age groups females experienced unacceptable behaviour at higher rates than males, and female survey participants aged 17 to 30 experienced the highest rates.³²
28. A greater proportion of female survey participants reported experiencing bullying, non-sexual harassment, abuse of power, sexual misconduct and sexual harassment than male survey participants in the same survey period. However, they are not the only cohort of serving members at disproportionate risk of experiencing unacceptable behaviour.

9.2.3 High-risk locations and cohorts

29. We heard evidence that more incidents of unacceptable behaviour are perpetrated against particular groups in the ADF. The Commonwealth agrees that toxic subcultures (or 'microcultures') exist in the ADF, and that 'it has a poor track record for identifying, managing and preventing the development of toxic cultures within the ADF'.³³
30. Unacceptable behaviour is more prevalent in some training institutions, at 'bad bases', in closed or insular environments, such as on ships or in certain units,³⁴ and in groups where toxic subcultures emerge. It is also more likely to be directed towards certain demographic populations, such as women or members who are perceived as different.

Women

31. Based on our analysis, women in the ADF are at an increased risk of experiencing unacceptable behaviour compared with their male colleagues. For some types of unacceptable behaviour, the discrepancy between the experiences of men and women in the ADF is very stark.³⁵
32. The 2017–2022 Pathway to Change report states that women 'continue to experience unacceptable behaviour at higher rates than male counterparts' and are 'twice as likely to experience sexual-related unacceptable behaviour'.³⁶
33. As we discuss in Chapter 1, Understanding suicide, Chapter 18, Health care for ex-serving ADF members, Chapter 7, Culture and leadership, and Chapter 8, Military sexual violence, ex-serving women who served in the permanent forces are 2.1 times (110%) more likely to die by suicide than Australian women.³⁷

Members perceived as ‘different’ or ‘outsiders’

34. Historically, serving members who were perceived as being in some way different to the norm were often singled out for violence and abuse.³⁸ According to the Defence Abuse Response Taskforce (DART), this misconduct:

stemmed from the idea that certain characteristics make a suitable member of Defence, as well as a culture of denigrating and isolating those who, for whatever reason, did not fit the particular Defence mould.³⁹

35. These personal characteristics included age (being younger or much older than your cohort); perceived physical weakness, including injury or illness; race; religion; and sexuality and/or perceived sexuality.⁴⁰ Chapter 7 provides more information about the deep culture of tribalism that defines certain aspects of service life.
36. Evidence from previous inquiries has indicated that members suffering from injury or illness may be at particular risk of unacceptable behaviour.⁴¹ In the DART’s November 2014 *Report on Abuse in Defence*, the Taskforce discussed the stigma associated with illness or injury in the Army; one complainant stated that he was ‘treated like a second-class citizen and punished and bastardised every single day for being injured’.⁴²
37. The same report also stated that:

Complainants commonly reported having had a medical certificate questioned or disregarded in an aggressive manner, or being ordered to participate in activities while ill or in breach of medication restrictions, sometimes under threat of being charged with disobeying a direct order. A large number of complainants also reported being subjected to verbal abuse on the basis of a medical condition such as being called ‘useless’, a ‘liar’, ‘whinger’, ‘malingerer’ or a ‘bludger’.⁴³

38. Those who are considered ‘other’ or in the ‘out’ groups may be at particular risk of unacceptable behaviour, including women, First Nations people, people from culturally and linguistically diverse backgrounds and LGBTIQ+ people.⁴⁴
39. In fact, the former Sex Discrimination Commissioner, Ms Kate Jenkins AO, said that addressing unacceptable behaviour directed at First Nations members, members from culturally and linguistically diverse backgrounds and LGBTIQ+ members was a ‘pressing cultural reform issue’ for Defence.⁴⁵

Training institutions

40. We have heard many accounts of serving and ex-serving members who experienced unacceptable behaviour during training, particularly at *ab initio* (‘from the beginning’) training institutions and during initial employment training.⁴⁶ This has been a key focus of previous inquiries into abuse in the ADF.⁴⁷

41. These accounts are supported by the results of Defence's Workplace Behaviour Survey, which we analyse in Appendix L, Defence survey data. Our analysis indicates that from 2020 to 2022, permanent ADF members from the ADFA, the Royal Australian Naval College and the Royal Military College, Duntroon experienced unacceptable behaviour at a rate that was often higher than the survey average.⁴⁸ Experiences of unacceptable behaviour at training institutions that introduce a vulnerable cohort of individuals into service life may compound existing risks.⁴⁹
42. As discussed in Chapter 3, Recruitment and initial training, we are deeply concerned that certain aspects of ADF culture that relate particularly to the training of recruits create an environment in which some people believe it is acceptable to harass, intimidate, bully, abuse or commit violence against others.
43. The Commonwealth agrees, noting that 'the rates of unacceptable behaviour are higher at some ADF training institutions than the wider ADF' and that 'experiences of unacceptable behaviour at Defence training establishments may compound the risk of suicide and suicidality'.⁵⁰

'Bad bases' and toxic subcultures

44. We have heard of particular bases, units and battalions, and groups in which toxic subcultures have developed where unacceptable behaviour and egregious forms of misconduct have gone unchecked.⁵¹ Numerous reviews and inquiries have uncovered historical examples of 'bad subcultures' or 'bad bases' across the ADF.⁵²
45. Defence itself accepts that toxic subcultures or 'micro-cultures' can and do emerge across the ADF. We were told by notice that there have been occasions over Defence's history 'where conduct and performance can deviate from the standards and values expected of members of the ADF'.⁵³ An example given was the Brereton Afghanistan Inquiry report, which provided 'examples of such cultures and attitudes which enabled, or masked if [not] encouraged, misconduct'.⁵⁴ The notice went on to say:

History also shows that Defence has uncovered circumstances where poor leadership or other risk factors can lead to the normalisation of bad behaviour leading to the development of unacceptable micro-cultures within specific areas of the ADF.⁵⁵

46. Contemporary examples of poor subcultures have been uncovered by Defence and the Inspector-General of the ADF (the IGADF). A 2022 Military Justice Performance Audit conducted by the IGADF of the 8th/12th Regiment, Royal Australian Artillery Army, located at Robertson Barracks in Darwin, found that its military justice processes and practices were '*materially deficient* due to [the] identification of misogynistic behaviours and potential stifling of complaints'.⁵⁶

47. The IGADF audit report of this regiment reported that women in particular had told the IGADF about appalling and ongoing incidents of sexism, inappropriate comments and sexual misconduct in an environment in which these attitudes were enabled by the chain of command, including by blocking complaints or sweeping incidents 'under the rug'.⁵⁷
48. But for the periodic Military Justice Performance Audits undertaken by the IGADF, Defence would not have known about the serious problems plaguing the 8th/12th Regiment. Neither the Senior ADF Officer at Robertson Barracks nor the Commanding Officer of the 8th/12th Regiment were aware of the levels or the extent of the unacceptable behaviour being perpetrated under their command.⁵⁸ During Hearing Block 12, the Chief of Army, Lieutenant General Simon Stuart AO DSC, accepted that this was reason for concern.⁵⁹
49. In referring to this example, we are not suggesting that these senior ADF officers are to blame for these problems or that they exercised poor leadership. In fact, the decisive actions taken by the Commanding Officer of the 8th/12th in response to these findings should be commended.⁶⁰
50. Certain kinds of closed or insular military environments, such as those onboard a Navy ship, can exacerbate the negative experiences of members exposed to harassment, violence or abuse because those onboard have nowhere to go. As a serving member of the Navy told us:
- During my posting to HMAS [Redacted], my work colleagues and I experienced bullying from our direct chain of command ... This was reported to the ship's CO [commanding officer], XO [executive officer], CWO [chief warrant officer] ... Padre, E&D [equity and diversity] advisor, and to members of the Sea Training Group and Fleet Health Division ... I asked not to be posted in the same location as [the two members who had bullied me], and I was told there was nothing on my file ... We repeatedly asked for help and received none. We regularly discussed how we understood now why so many serving members took their own lives, to be stuck in a work place where no one would help you and you have months/ years still left in that workplace, stuck.⁶¹
51. These examples demonstrate the alarming reality: toxic subcultures still flourish in the ADF today, even under the command of compassionate leaders, and especially in their absence. As we will explore later in this chapter, without a strong reporting culture, it may be inevitable that toxic subcultures end up flourishing in pockets of the ADF. If Defence is serious about addressing unacceptable behaviour, it cannot simply rely on periodic audits by the IGADF to identify the locations where misconduct has gone unchecked.
52. As Lieutenant General Stuart acknowledged, in his view, there is a need for improved and more timely mechanisms to identify such examples of poor subculture.⁶²

Learning from other jurisdictions

53. During our visit to the United States, we learnt about the US Armed Forces' On-Site Installation Evaluations. Under this program, 20 military 'sites' (that is, bases) were identified via survey data as either protective or high-risk locations for sexual assault, harassment and suicide. On-site evaluations were undertaken of these locations to determine whether they were effectively preventing harm to serving members. A public report was issued in 2022 that 'nam[ed] and sham[ed]' sites that performed poorly, made recommendations and identified positive initiatives that could be replicated in other locations.⁶³ In Australia, Defence does not currently undertake this kind of targeted evaluation or publicly report high-performing or high-risk locations.

9.3 Effects of unacceptable behaviour on member health and wellbeing

54. Experiencing unacceptable behaviour as a serving member and the effects of how the misconduct is managed by the organisation can have a profound, sometimes lifelong, impact on serving and ex-serving members. This has been the subject of numerous inquiries.⁶⁴ Former serving member, Danielle Wilson, a lived-experience witness, told us:

They need to know the impact that this has on people. It might just seem like a joke or a bit of banter to them but it's not. It is impactful. It stays with someone their whole life. They don't have the right to take those liberties with somebody. They don't have the right to touch someone, to assault someone, to verbally abuse someone. There needs to be training to know it's not tolerable; it is not acceptable, especially in this day and age. If it happened to their daughter, how would they feel?⁶⁵

55. The Hon Leonard (Len) Roberts-Smith RFD KC, former Chair of the DART, told us that serious abuse in the ADF, and the mismanagement of abuse, has had 'very serious impacts on the lives and careers of those who experienced it, both at the time of the abuse and for many years afterwards'.⁶⁶ His observations were that there were immediate effects, including physical and psychological harm, and longer-term effects that caused 'severe emotional distress, ruined careers, [led to] relationship break downs, drug and alcohol addictions, psychological disorders, suicidal ideation, social isolation and many othe[r issues]'.⁶⁷
56. 'Latent harm' refers to 'injuries or illnesses, including psychological conditions ... [that] may have a slow or delayed onset, manifesting sometime after exposure to a particular hazard in the workplace'.⁶⁸ The experience of unacceptable behaviour can be a risk factor for suicide and suicidality that sometimes does not fully emerge until a long time after the initial incident.

57. In addition to a large number of lived-experience accounts and testimony from expert witnesses, our analysis of Defence's Workplace Behaviour Survey data informed our understanding of how unacceptable behaviour negatively affects the physical and mental wellbeing of serving members.
58. Based on how members answer nine questions about their day-to-day experiences and perceptions of the workplace, the ADF can determine 'whether respondents believe Defence cares about their psychological and physical wellbeing'.⁶⁹ Participants' responses can then 'be used as indicators of respondents' overall sense of safety within Defence'.
59. In Defence's published reports, members' reported levels of psychosocial safety are often presented as high or even very high. However, these findings often fail to disaggregate the responses of male and female respondents, which has the advertent or inadvertent effect of concealing the significantly lower levels of psychosocial safety reported by women in the ADF.
60. For example, a whole-of-Defence survey from September 2020, reporting results from 2018 to 2020, demonstrated that the reported psychosocial safety of ADF members remained consistent and fairly positive over that period.⁷⁰ On a scale of 1 to 5, where 1 represents negative and 5 represents positive, Defence scored just under 4 across the 3 years.
61. We are unable to disaggregate the psychosocial safety scores for men and women from reports of the survey results. Defence often does not disaggregate its data, or at least the presentation of the data, which can reduce the effectiveness of the data collection itself. In this instance, it has also prevented us from gaining insights into the psychosocial safety of ADF members.
62. However, upon interrogating the data, we found that survey respondents who had experienced unacceptable behaviour in the previous 12 months reported significantly lower levels of psychosocial safety. For example, in 2022, 43% of participants who experienced unacceptable behaviour were rated as being at very high or high psychosocial risk, compared to only 9% of those who did not experience unacceptable behaviour. This analysis is presented in more detail in Appendix L, Defence survey data.
63. For permanent serving survey participants who experienced unacceptable behaviour in the previous 12 months, our analysis revealed that for some individuals, these experiences had substantial impacts on their sense of safety, their mental health and their work.⁷¹ For example:
- Almost 9 in 10 of the survey participants indicated that the experience had some effect (from 'little' to 'extreme') on their mental health, with over 40% saying it had a 'very' or an 'extremely' negative impact on their mental health.
 - Almost 80% of the survey participants indicated that the experience had at least some negative impact on their work (from 'little' to 'extreme'), with around 30% saying it had a 'very' or an 'extremely' negative impact on their work.

- Over half of the survey participants indicated they felt intimidated or unsafe to some degree (from 'a little' to 'extreme'), with around 20% saying they felt 'very' or 'extremely' intimidated or unsafe
- Approximately one quarter of the survey participants who experienced unacceptable behaviour took unplanned leave as a result of their experiences.⁷²

64. These figures are consistent across the period 2018 to 2023.⁷³

9.3.1 Unacceptable behaviour as a risk factor for suicide and suicidality

65. We have heard and read many lived-experience accounts detailing how experiencing unacceptable behaviour has led to suicide and suicidality. In our interim report, we discussed some of the evidence connecting suicide and suicidality with experiences of misconduct, violence and abuse in the ADF, and Defence's handling of that behaviour.⁷⁴ We are not the first inquiry to identify this connection; previous reviews have also identified this connection.⁷⁵

66. In a written statement provided to the Royal Commission, The Hon Len Roberts-Smith said, 'there can be absolutely no doubt' that serious abuse in the ADF, and its mismanagement, is a risk factor for suicide and suicidality.⁷⁶ He provided us with numerous personal stories, communicated to the DART, of ADF personnel, serving and ex-serving, who experienced suicidality 'irrespective of when that [abuse] had occurred or the nature of the abuse'.

67. One complainant told the DART:

How has the incident impacted my life? To this day, the impact cannot be measured but is still felt far too often. It has shaped much of who I now am and all that I do. I suffered chronic depression as a result and even attempted suicide when at my lowest point. I was diagnosed with post-traumatic stress disorder ... and it is evident to this day. I still have ongoing self-esteem, anxiety and depression issues.⁷⁷

68. During our inquiry, numerous senior leaders in Defence acknowledged unacceptable behaviour as a potential risk factor for suicide and suicidality.⁷⁸ This is also reflected in DVA policy documents that describe how survivors of abuse may lose interest in day-to-day activities and feel isolated, guilty, ashamed and angry.⁷⁹ The documents also identify that with time, other issues may emerge such as 'depression, sexual difficulties, substance abuse, eating disorders, self-harm, and suicidality'.⁸⁰

69. A literature review by Phoenix Australia, funded by the Royal Commission, provided evidence supporting the conclusion that experiences of physical violence during service can be a risk factor for suicide and suicidality.⁸¹ Chapter 8, Military sexual violence, provides a summary of the relevant academic literature linking military sexual trauma to suicide and suicidality.

70. While there is limited academic literature examining connections between non-sexual forms of unacceptable behaviour and suicide and suicidality, it has been the subject of numerous studies. In the US, studies have shown that physical abuse and physical assault can contribute to suicide attempts by, and suicidal ideation in, service members.⁸² According to a 2006 study from the United States, a sample of veterans being treated for substance abuse disorders who experienced physical abuse in the previous 30 days were three times as likely to attempt suicide than those who had not experienced abuse.⁸³
71. As part of its literature review, Phoenix Australia also compiled evidence showing that experiences of hazing and bullying during military service were associated with suicidality, as well as mental health outcomes that may themselves increase the risk of suicidality.⁸⁴ For example, a 2019 study from the United States found that experiences of bullying in the military were associated with perceived burdensomeness, which is an indicator of higher rates of suicidal ideation.⁸⁵
72. Further research is required to have a precise understanding of the connection between unacceptable behaviour, particularly non-sexual unacceptable behaviour, and suicide and suicidality. Nonetheless, there is sufficient evidence before us to establish the detrimental effects of unacceptable behaviour and the poor handling of that unacceptable behaviour on the mental health of members.

9.4 Drivers of unacceptable behaviour in the ADF

73. The attention on cultural reform in Defence for more than a decade reflects the influence of factors, such as military culture, embedded in military norms and structure, on the perpetuation of unacceptable behaviour.⁸⁶ Some Defence documents identify these factors as ‘root causes’.⁸⁷ For the purpose of this part of the report, we will define them as ‘drivers’, using the definition in the Set the Standard Report, which describes them as ‘systemic and structural’ and refers to ‘societal dynamics or “root causes”, such as gender inequality’.⁸⁸
74. Drivers create an environment that enables harm to occur, and ‘cannot be reduced to individual choices and behaviour’.⁸⁹ This is acknowledged by Defence in its ‘Respect@ Work Framework’, which states:

Understanding the drivers of unacceptable behaviour in the workplace and the factors which increase the risk of such behaviours occurring is an important precondition to establishing good prevention and response initiatives to reframe cultural change.⁹⁰

9.4.1 Cultural drivers

75. We have identified some of the key cultural drivers contributing to unacceptable behaviour in the ADF as:

- a lack of diversity⁹¹
- the traditionally masculine culture of the ADF⁹²
- tribalism⁹³
- loyalty to the unit, which means adhering to the 'code of silence' and not 'dobbing on' one's mates⁹⁴
- a culture of endurance, where members are told to 'suck it up' and push through injury, illness and grievances⁹⁵
- power imbalance and unquestioned obedience to the chain of command, restricting a member's ability to report abuse⁹⁶
- a lack of accountability.⁹⁷

76. These issues are explored in more detail in Chapter 7, Culture and leadership.

77. In 2011, Defence acknowledged tribalism and the ADF's male-dominated environment as drivers of unacceptable behaviour. As Major General Craig Orme AM CSC (Retd) wrote in his report, entitled *Beyond Compliance: Professionalism, Trust and Capability in the Australian Profession of Arms* (the Orme Review), a tension exists between the 'tight' military culture of 'shared identity, clear norms and role requirements and social stratification',⁹⁸ and the consequences of this culture. In the highly stratified ADF culture:

'insiders' are those who are socially strong and conform to the cultural ideal; the 'outsiders' are those who are judged to fail in or pose a risk for the culture or are not accepted as part of the winning group. These are generally cultural minorities such as women, ethnic members, sometimes those who are injured, or those with a different sexual persuasion.⁹⁹

78. As we discuss in Chapter 7, while a deep sense of loyalty to a unit can be a protective factor for members, it can also drive a culture of unacceptable behaviour. Mr Robert Cornall AO, who served as Chair of the DART from late 2014 to March 2016, explained that there are two military cultures that interact poorly with each other.¹⁰⁰ The first is that you support your mates under any circumstances; the second is that 'you don't dob on your mates, even if your mate has just raped you and committed a very serious criminal offence on you'.¹⁰¹

79. To understand these dynamics, one must recognise that there is sometimes a disconnect between the overt values and policies of the organisation, and ‘how things are done around here’, which was the informal definition Major General Peter Dunn AO (Retd) gave for ‘organisational culture’ in his evidence.¹⁰² As such, situations may arise that it would be Defence policy to report (for example, an instance of unacceptable behaviour); however, the way in which ‘things are done around here’ is to stay silent on the matter.
80. On this topic, we have heard of many instances in which a victim or observer of unacceptable behaviour makes a complaint, and is bullied, harassed or ostracised as a result. This can lead serving members to abandon their career in the ADF.¹⁰³ When this behaviour is combined with a lack of accountability or adverse consequences for the abuser – something we have also heard evidence about – the effects can be significantly worse for the member who has spoken up.¹⁰⁴ These dynamics are frequently reinforced by the ADF’s strict hierarchy and centrality of the chain of command.¹⁰⁵
81. Thus, there is an aspect of ADF culture that discourages, and even punishes, the reporting of abuse, despite the fact that its stated values are the exact opposite. Instead of reporting unacceptable behaviour, members receive overt and more subtle messages to ‘suck it up’ and ‘toughen up’. This opens the door for those with power to bully, harass and abuse with impunity. This aspect of ADF culture will be discussed in more detail throughout this chapter.
82. When asked about the term ‘military institutional abuse’, Major General Dunn, who first introduced and then led the Defence Personnel Executive, now the Defence People Group, agreed that it was a characteristic of military culture. He said that institutionalised abuse occurred ‘not through deliberate acts’ but by perpetuating the way that things have always been done.¹⁰⁶
83. Previous reports certainly support that position. A 2018 insights report, produced as part of a Defence review into the handling of unacceptable behaviour complaints, found that:
- there is a degree of acceptance [that unacceptable behaviour is entrenched] resulting in genuine issues not coming forward and repeated incidents that are left to continue because there is little deterrence.¹⁰⁷
84. Similarly, the DART’s 2014 *Report on Abuse in Defence*, found that ingrained hierarchies have restricted the reporting of abuse, as people in perceived or actual positions of power often know of or implicitly endorse the abuse.¹⁰⁸ This leads perpetrators to conclude that there are no consequences for their actions.¹⁰⁹
85. In 2017, the Australian Human Rights Commission (AHRC) also found that one of the drivers for unacceptable behaviour in the ADF is the lack of support for reporting unacceptable behaviour. It stated that many individuals in the ADF, including senior leaders, see a certain amount of unacceptable behaviour as part of ADF culture and necessary to drive capability.¹¹⁰

86. This reinforces the most toxic elements of a culture of endurance, in which members are taught to 'shut up', toughen up' and 'get over' experiences of unacceptable behaviour, however harmful. These deeply ingrained cultural issues perpetuate unacceptable behaviour and set up significant structural and psycho-social obstacles that prevent members from speaking up. This needs to change if the ADF is to recruit and keep members, fulfil its duty of care not to expose people to avoidable harm, and thus optimise its operational capability.

9.4.2 The influence of alcohol

87. Heavy alcohol consumption, including binge drinking, has been a longstanding feature of military culture in many Western countries.¹¹¹ Academic studies have found that risky drinking is most common among serving members who are younger, lower ranked and male.¹¹²
88. Previous inquiries have also recognised that the misuse of alcohol has been a risk factor for abuse in the ADF.¹¹³ In its analysis of complaints of historical abuse, the DART found that alcohol consumption was a feature of many cases of bullying, harassment and violent behaviour, including instances of hazing and bastardisation. The taskforce singled out the prevalence of alcohol consumption – by both victims and perpetrators – in complaints of sexual assault; many complainants reported being sexually assaulted after a social event.¹¹⁴
89. According to the DART, the complaints:
- suggest the existence of an entrenched culture of alcohol abuse, where the consumption of large amounts of alcohol is encouraged as integral and necessary in building camaraderie, shared experiences, and being accepted as a member of the team. This is particularly concerning in the many situations where complainants – many of whom were particularly young and vulnerable in the early stages of their careers – were provided alcohol by their peers or superiors, and felt under considerable pressure to acquiesce out of fear of the potential repercussions of declining an offer by those with whom they would have to work closely, or who held a higher rank.¹¹⁵
90. This association between alcohol misuse and unacceptable behaviour is consistent with the broader civilian literature. Alcohol can be a contributing factor to, but is not a cause of, violence and misconduct in the workplace. It may 'weaken pro-social behaviour', reinforce toxic displays of masculinity, increase aggression and confidence, and lead to the misreading of social cues.¹¹⁶
91. We also explore issues related to the consumption of alcohol among ADF personnel in Chapter 8.

9.5 Understanding and addressing unacceptable behaviour

92. In many ways, the starting point for understanding Defence's contemporary approach to unacceptable behaviour is the so-called 'Skype incident' and the two iterations of the cultural reform plan 'Pathway to Change' that it precipitated. These are examined in detail in Chapter 7; however, we will also refer to them in this chapter.¹¹⁷
93. Defence's current multi-faceted approach to addressing unacceptable behaviour comprises six priorities:
- The crucial capture and management of information and data about unacceptable behaviour, whether it be through anonymous surveys, military justice processes, Defence support services, processes of the Inspector-General of the ADF and other inquiries, or informal means, such as conversations between leaders.¹¹⁸
 - A renewed focus on leadership in relation to unacceptable behaviour. Defence's leaders are responsible for the management of complaints, for upholding Defence's purported values and behaviours, and for ensuring that those under their command comply with and trust Defence's complaints processes.¹¹⁹
 - The provision of mandatory training and education about unacceptable behaviour during members' initial training and as part of their annual training thereafter.¹²⁰
 - The prevention of unacceptable behaviour. While arguably the most underdeveloped component of Defence's management of unacceptable behaviour, prevention is referred to in statements, policies and directives we have received from Defence.¹²¹
 - The provision of support to members affected by unacceptable behaviour is a priority. Such support includes counselling, medical or clinical support services, assistance with navigating and resolving complaints, and other support services offered or referred to by Defence.¹²²
 - Undertaking complaints management. Defence views complaints management as critical for maintaining order and discipline, preventing unacceptable behaviour and delivering fair outcomes for all impacted parties.¹²³
94. Of these six priorities, we will treat the first five in the coming sections, and we will discuss the sixth, complaints management, in detail as a stand-alone area.

9.5.1 Data on unacceptable behaviour collected by Defence

95. Defence has access to many data sources of information that could assist senior leaders to gain both a targeted and a longitudinal perspective of the prevalence of unacceptable behaviour in the ADF and the factors associated with it.

Defence data on unacceptable behaviour is disparate and disjointed

96. Defence's data collection and analysis is inconsistent across the services. Defence collects and analyses data as follows:
- The Defence People Group in the Department of Defence administers a range of anonymous (voluntary) surveys.¹²⁴ These surveys, further described in Chapter 29, Use of data and research by Defence and DVA, include:
 - Workplace Behaviour Surveys
 - YourSay Workplace Experience Surveys
 - Profile of Unit Leadership, Satisfaction and Effectiveness (PULSE) Surveys.
 - Other surveys are administered by specific services, and most notably include the Navy's 'Organisational Culture Inventory' and 'Organisational Effectiveness Inventory', and the Air Force's 'Snapshot' surveys.¹²⁵
 - All reported incidents of unacceptable behaviour must be recorded by commanders and supervisors in the 'ComTrack' database. This includes records of the initial incident, progress reports, and military justice, administrative and/or disciplinary outcomes. The recording of this information assists leaders to identify patterns of behaviour and analyse the statistics.¹²⁶ Previous inquiries have identified some of the limitations of this database as a mechanism for statistical analysis.¹²⁷ As we discuss in section 9.6.5, incident data is recorded in several internal databases, and this disparity has reduced Defence's capacity to understand, analyse and address unacceptable behaviour effectively.¹²⁸
 - Data is also collected by the Sexual Misconduct Prevention and Response Office (SeMPRO). This is discussed further in Chapter 8, Military sexual violence.¹²⁹
 - Different kinds of incident data are compiled by the Joint Military Police Unit and the Office of the Director of Military Prosecutions.¹³⁰
 - Additional incident management data is collected by the individual services.¹³¹
97. This list is far from exhaustive, and does not attempt to capture data that is collected by other institutions connected to Defence, such as the Inspector-General of the ADF and the Defence Force Ombudsman.¹³²
98. Defence has acknowledged that its collection of data is disjointed generally, including in relation to the data collected on unacceptable behaviour.¹³³ Evidence we have gathered describes the ADF's current processes of sexual misconduct data collection as 'inconsistent, sometimes baffling' and as 'a scattering of jigsaw pieces that have not yet been put in place to form the whole picture'.¹³⁴

Defence fails to learn from its data on unacceptable behaviour

99. Ms Alexandra Shehadie, who undertook work on the reviews of the treatment of women in the Australian Defence Force Academy and ADF with former Sex Discrimination Commissioner Ms Elizabeth Broderick AO, told us:

Defence didn't know if or where predators were in the organisation, because the data just wasn't there and it was inconsistent. There wasn't – we didn't know whether certain bases were problematic, those sorts of things, what was going on, why weren't people reporting, what were the incidents of this, what was the prevalence.¹³⁵

100. We are concerned that Defence is failing to compile, use and learn from the vast amounts of unacceptable behaviour data it collects each year. We have seen numerous examples of these failings. We heard that year after year, ADFA receives Workplace Behaviour Survey results that indicate alarming levels of unacceptable behaviour.¹³⁶ However, we were told that these results were not sufficiently granular or detailed to support ADFA's leadership to take targeted action in response.¹³⁷

101. This issue was identified by the Commandant of ADFA, Air Commodore Julie Adams, who suggested that the survey data could be made more 'useable' by aligning the survey with the university sector's National Student Safety Survey; however, this was not done in the following round of Workplace Behaviours Surveys.¹³⁸

102. In an email to the Department of Defence, Air Commodore Adams expressed her desire to be able to take targeted action in relation to the annual survey, writing:

I would really like to be able to take some targeted action I can refer to when we are next asked to comment, rather than roll out the same list of initiative[s] that do not appear to change the statistics materially year by year.¹³⁹

103. We raised concerns with the Deputy Secretary of Defence People, Ms Justine Greig PSM. Ms Greig acknowledged that the Department of Defence had failed to manage and use survey data effectively.¹⁴⁰ In particular, she recognised that:

- The Defence People Group has been too slow in providing survey reports to commanders to enable them to learn from and act on that data.¹⁴¹
- Commanders are not provided with sufficient support to learn from the data collected by the Defence People Group.¹⁴²
- More needs to be done to ensure that commanders are acting on the findings of the surveys conducted, including appropriate follow-ups.¹⁴³
- The lack of granular results at the unit level negatively impacted commanders' ability to take meaningful, targeted action.¹⁴⁴
- Defence's numerous survey instruments and the data collected from those surveys need to be collated more appropriately.¹⁴⁵

104. While we are encouraged by Ms Greig's acknowledgement of these problems, and her stated commitment to address them, we cannot but emphasise Defence's previous lack of action to rectify them.

105. For example, during our examination of the Commanding Officer of the 1st Recruit Training Battalion, Colonel Andrew Deacon, we heard that at the time of the hearing on 29 November 2022, Colonel Deacon was yet to receive the 2021 Workplace Behaviour Survey results for his training institution.¹⁴⁶ We know that these results were available, as they had been provided to the Royal Commission more than a month prior to the hearing date.¹⁴⁷

106. A disappointing trend throughout our inquiry has been the tendency for some leaders in the ADF to put a positive spin on unacceptable behaviour survey data instead of acknowledging that there is a problem, and it is causing harm.¹⁴⁸ As one of our Counsel Assisting put it to Ms Greig:

There are two main interpretations that we hear, depending on the [survey] result. The first is that ... if there's an increase [in the prevalence of a form of unacceptable behaviour] ... the interpretation is that the reporting culture has improved, which is a good thing. And if the line is going the other way, the interpretation is that the substantive problem is improving. Those are the two interpretations we keep getting.¹⁴⁹

107. Even some of the most senior members of the ADF have framed survey results in these terms. During Hearing Block 3, the then Chief of Navy, Vice Admiral Michael Noonan AO RAN, was asked whether historical data compiled by the Defence Abuse Response Taskforce (DART) may have indicated a proportionally high incidence of sexual abuse and sexual harassment on Naval ships from 2000 to 2011.¹⁵⁰ In response to this question, Vice Admiral Noonan said:

No, I do not agree that this necessarily means a higher degree of abuse and harassment on ships. What the report indicates is a higher degree of reporting ... I'm familiar with this report and the statistics that it provides. I do not contest the statistics, but I do offer the context that during that period, Navy was well advanced with its cultural change program, particularly around ensuring that people felt that they could come forward and report cases. In your very first question, the culture of silence that had previously existed was something that had been well addressed during – by this period.¹⁵¹

108. The data on which Vice Admiral Noonan was commenting was entirely independent of Defence and was collected from public submissions that related to incidents that would have taken place many years earlier. Vice Admiral Noonan would have no way of knowing whether or not these complainants were influenced by the Navy's cultural reform programs and would have no way of knowing whether they had positive reporting experiences at the time of the abuse.

109. The very fact that these complaints were made to the DART likely indicates that the abuse was *not* well handled at the time, particularly given that 97% of the reparation payments granted under the scheme included a payment that acknowledged some form of Defence mismanagement of the abuse.¹⁵² These comments from leaders, in and of themselves, may impact members' confidence to report incidents of unacceptable behaviour.

9.5.2 The role of leaders in transforming culture

110. Throughout this inquiry, we have consistently heard that strong leadership is required to address unacceptable behaviour and transform ADF culture.¹⁵³ ADF leadership is covered in other sections of this report, particularly in Chapter 7, Culture and leadership, which recognises that while a hierarchical command and control structure is required for military operations, it can often discourage cultural change.¹⁵⁴
111. Leaders are an important driver of how unacceptable behaviour is managed and should be acknowledged as one of the mechanisms through which a reduction of unacceptable behaviour must occur. In his statement, the then Chief of the Defence Force, General Angus Campbell AO DSC wrote:

To maximise Defence's capability, and sustain the trust of Government, the Australian community and each other, we must take the best of our culture forward, and hold to account those who do not meet our required standards.

Creating a positive culture, where our people live by the Defence values and behave accordingly, is at the heart of our reforms and what I have been seeking to achieve.¹⁵⁵

112. In describing the relationship between leaders and culture, Mr Dunn stated:

organisational climate is directly and very quickly influenced by leadership, and that is what really impacts on the individuals. It is something that is still, to this day, not well understood, whereas organisational culture, how things are done around here, could in fact be a process that might be archaic, it might be almost historic but it's still a good place to work, and it doesn't necessarily affect the individuals' wellbeing, but organisational climate does, [and is] a direct outcome of the leader.¹⁵⁶

113. In Chapter 7 we explore this issue in detail, including the steps that Defence must take to effectively hold leaders to account for unacceptable behaviour that happens under their command.

9.5.3 The importance of training and education

114. Behavioural training refers to training undertaken throughout service life to promote positive values and prevent and address unacceptable behaviour. It can play a critical role in building a safe and supportive workplace, particularly when undertaken in combination with effective ethical and leadership training. While the service chiefs believe that 'frequent training and education is an important strategy that contributes to cultural change',¹⁵⁷ Professor Megan MacKenzie, Simons Chair in International Law and Human Security at Simon Fraser University, Canada, was more circumspect, stating:

I have looked at training for leadership. I've looked at officer training in the US, in particular. I guess what I would say is training is a very limited tool. When you think of a service member who has had an entire career in a particular

environment and has thrived or either been part of unacceptable behaviours or turned a blind eye around unacceptable behaviours, that when those individuals potentially reach leadership positions, I'm not sure that training is enough to provide significant cultural change.¹⁵⁸

115. This raises the question of what kind of training would be effective. Mental health expert and founder of the Black Dog Institute, Professor Gordon Parker AO, told us that mandatory training can sometimes be a tokenistic response by organisations to address their problems.¹⁵⁹

116. Our recommendations with respect to the education and training regime will only be effective if they are also accompanied by the systemic reforms we have detailed throughout this report.¹⁶⁰ As the AHRC stated, summarising a United Nations' discussion paper on sexual misconduct training:

training can be an important tool to drive positive cultural change on equality and inclusion in an organisation, which can, in turn, help prevent and improve responses to sexual harassment. However, to achieve this goal, it is vital that training not be viewed in isolation –instead it must be 'conceived and practiced as part of a process of organisational change', of the construction of respectful and non-discriminatory workplaces, and as a 'tool for establishing collective ownership of that process of change'.¹⁶¹

117. We could not agree more. We believe that when properly developed and implemented effectively, behavioural training complements other elements of organisational change, even though, on its own, it is unlikely to be sufficient to drive change.

Deficiencies of behavioural training in the ADF

118. New recruits undergo behavioural training during their *ab initio* training, often in the very first days and weeks after they begin.¹⁶² This training has a variety of important aims, including supporting new recruits to cultivate healthy relationships and explaining how to make a complaint about unacceptable behaviour.¹⁶³

119. Throughout service life, all serving members are required to complete mandatory awareness training, and each year, serving members may undertake a range of mandatory and voluntary training about unacceptable behaviour.¹⁶⁴ According to the Military Personnel Policy Manual (MILPERSMAN), this training is necessary to ensure members 'understand their workplace responsibilities which include developing and maintaining a safe and secure work environment and behaving ethically at all times'.¹⁶⁵

120. There is also a range of specialised and voluntary behavioural training that members may undertake during service life on topics such as how to conduct a 'fact-finding' process and how command should manage a complaint of unacceptable behaviour. Some of this training is delivered on request, and some may be undertaken as part of getting a promotion or when a member starts a new role or posting.¹⁶⁶

121. Behavioural training within the ADF has two broad aims:
- (1) building awareness and understanding of policies, processes and procedures. This includes informing members of what is and what is not unacceptable behaviour, of their responsibility to uphold 'Defence Values and Behaviour', of the processes around the reporting and management of unacceptable behaviour and the avenues available to members for advice and support¹⁶⁷
 - (2) changing behaviour and culture. This is about building a positive culture within Defence and creating a safe and supportive workplace.¹⁶⁸
122. The second aim is reflected in statements from senior ADF leaders.¹⁶⁹ Then Chief of the Defence Force, General Campbell, told the Royal Commission that mandatory behavioural training is not only directed at education about relevant policies and obligations but is also about 'embedding Defence Values and Behaviours' among members.¹⁷⁰
123. Similarly, a 2022 directive from the Chief of Army states that the purpose of Army's mandatory training program, which includes mandatory behavioural training, is to ensure that members 'are able to recognise risks to their physical, social and mental well-being, and have sufficient knowledge to take appropriate actions to mitigate those risks'.¹⁷¹
124. A 2023 review of the Defence cultural change initiative *Pathway to Change 2017–2022*, commissioned by Defence and undertaken by the Nous Group, indicates that Defence has had some success in achieving the first of these objectives. The review states that there has been 'an increase in awareness of desired behaviours over the duration of Pathway to Change'.¹⁷² It noted consultation in 2018 found that there were 'strong positive developments in the standards and benchmarks for workplace behaviour' and that behaviour that had been accepted in the past was no longer considered acceptable.¹⁷³
125. While these findings are promising, evidence collected by the Royal Commission indicates that for many members, the current training program has failed to build understanding and awareness about unacceptable behaviour.¹⁷⁴ Our inquiry also indicates that, for many members, the current training program has failed to achieve the more substantive aim of creating behavioural and cultural change.¹⁷⁵ Defence's failure to appropriately evaluate its behavioural training program has meant that it cannot say, with any confidence, that this training is making any meaningful difference to the behaviour of its members and the broader culture of the ADF.¹⁷⁶

Behavioural training may not be adequate or regular enough

126. We have heard that, at least for some serving members, mandatory behavioural training is a perfunctory, 'tick-the-box' exercise, rather than a meaningful and effective educative tool.¹⁷⁷

127. In the context of sexual misconduct, the Respect@Work report describes 'conventional training approaches' as 'misconceived'.¹⁷⁸ According to the AHRC, 'conventional training' typically involves compliance training, where participants learn about what constitutes poor behaviour, that it is prohibited and how to report that behaviour. Often this training is delivered when the person commences at a new workplace, and the training is then reinforced via annual (or less regular) follow-ups.¹⁷⁹ Although Defence is certainly more evolved in its development and delivery of behavioural training than other workplaces, this is still, essentially, the model used by the ADF for its mandatory behavioural program.¹⁸⁰
128. The AHRC describes several potential deficiencies with this form of training:
- It can often be a 'tick-the-box' compliance exercise, designed to protect employers from legal liability. Additionally, workers do not take it seriously'.¹⁸¹
 - It often relies on an online delivery format, which is known to be less effective.¹⁸²
 - There is usually insufficient follow-up to understand whether the training has been effective in reducing the incidence of bad behaviour.¹⁸³
 - It utilises 'an information-sharing format', rather than an engaging, participatory format.¹⁸⁴
 - It is not conducted regularly enough.¹⁸⁵
 - The training is too general in nature, and not sufficiently tailored to the needs of the target group.¹⁸⁶
 - When delivered ineffectively, it can be perceived negatively by the trainees, and lead to backlash against the training and the institution.¹⁸⁷
129. We have heard all of these criticisms in relation to Defence's behavioural training.¹⁸⁸ For example, we received a range of 'Learning Review Reports' for the Navy, many of which speak to members' experiences of Power Point being overused, a lack of balance and a desire for more practical instruction during *ab initio* training.¹⁸⁹
130. In part, the 'tick-and-flick' nature of some elements of the mandatory training curriculum could be attributed to a growing reliance on online learning. Since the beginning of the COVID pandemic, Defence has relied more and more on online learning systems.¹⁹⁰ This has enabled Defence to deliver a large volume of mandatory training to members within short timeframes without having to dedicate significant resources.¹⁹¹ In these kinds of programs, members report clicking through training courses without appropriately reading and absorbing the content.¹⁹²
131. E-Learning can be effective for some knowledge-based learning outcomes, including teaching about highly sensitive topics and providing 'pushed information' in a 'bite size learning format'.¹⁹³ However, it is not appropriate when the learning goals are complex, as they are when behavioural and cultural change are the desired outcomes.¹⁹⁴

132. In its 2023 review of unacceptable behaviour in Defence, the Commonwealth Ombudsman concluded that Defence's online mandatory unacceptable behaviour training 'is not seen as particularly effective'.¹⁹⁵ Even where behavioural training is delivered in-person, we have heard about a range of deficiencies with its delivery.¹⁹⁶
133. These real and perceived deficiencies mean that some members do not have a strong understanding of Defence policy and processes regarding unacceptable behaviour. As a consequence, Defence is failing to reach its much more significant aim of creating meaningful cultural and behavioural change.¹⁹⁷
134. Separate to questions about training quality, we have also heard that there are gaps in the content being delivered. Evidence indicates that many members are not receiving the training they need to identify and address unacceptable behaviour. Of particular concern is whether these knowledge gaps extend to those in management and command positions, who are responsible for handling complaints.¹⁹⁸
135. In its 2023 review, the Commonwealth Ombudsman provided a number of examples of leaders who felt unable or ill-prepared to appropriately deal with incidents of unacceptable behaviour, due to insufficient training. Notably:

[o]ne officer advised that although they wanted to ensure they applied a trauma-informed approach, they did not feel they had received enough information to know what this meant in practice or how to apply it. Others stated they received no training in vicarious trauma.¹⁹⁹
136. According to an internal brief obtained by the Royal Commission, some Naval officers ('across the ranks of Able and Leading Seaman, Petty and Chief Petty Officers and Lieutenants and Lieutenant Commanders') receive little to no targeted behavioural training throughout long stretches of their military career. The brief stated that, following initial employment training, some members may not receive formal workplace behaviour training, outside the 'tick-the-box' mandatory training, for anywhere between six and 10 years, or even more.²⁰⁰
137. To address this gap, the brief recommended the introduction of additional workplace training for these members.²⁰¹ However, Defence could not locate any evidence of this recommendation being implemented.²⁰² The Army and Air Force have not undertaken equivalent reviews to understand whether their services also have gaps of this kind.²⁰³
138. Throughout our inquiry, we have learnt about the significance of middle-ranking members in shaping the culture of the ADF. Middle-ranking personnel manage junior serving members, who may be at increased risk of suicide and suicidality, and provide day-to-day leadership for much of the ADF.²⁰⁴ According to former Sex Discrimination Commissioner, Elizabeth Broderick AO, 'middle managers' in institutions like the ADF, are the 'keepers of the culture'.²⁰⁵
139. Despite this, it is in the behavioural training of this precise cohort that we have found gaps.²⁰⁶ Further, and alarmingly, the Navy found that Naval officers at this level in the hierarchy are also overrepresented as alleged – and substantiated – perpetrators of unacceptable behaviour.²⁰⁷

140. Earlier in this chapter, we quoted the AHRC report, *Observations on Unacceptable Behaviour*, that stated that some ADF personnel believe that ‘a certain amount of unacceptable behaviour is part of the Defence culture and necessary to drive capability’.²⁰⁸ The report continues:

These views are predominantly held by middle-ranking, longer-serving members who are influential in unit dynamics. Of concern, they may also be the individuals responsible for dealing with any complaints of unacceptable behaviour.²⁰⁹

141. Clearly, it is this cohort that must be reached, not only by proper training, but also by initiatives for cultural reform. Ensuring these members receive targeted, evidence-based training is therefore critical, even if on its own, it is not sufficient.

Ineffective evaluation

142. Previous reviews and inquiries have found that Defence has not and does not effectively evaluate behavioural training.
143. In 2020, the Commonwealth Ombudsman examined the evaluation framework for behavioural training delivered by external educators in recruit schools. It found that ‘neither the department nor any of the services have a mechanism in place to provide assurance that the externally developed training is effective’.²¹⁰ The Ombudsman noted that ‘in particular, the healthy relationships and sexual ethics training package does not appear to be subject to any regular or systemic evaluation’.
144. Given the acknowledged necessity of cultural change in entrenched attitudes held by some Defence members and the critical importance of effective training as one piece of that complex puzzle, the absence of any *mechanism* for evaluating the effectiveness of training as recently as 2020 is deeply concerning.
145. The Commonwealth Ombudsman recommended that all behaviour training delivered at *ab initio* institutions should be evaluated to ensure its effectiveness and that Defence should amend its existing frameworks to ensure recruit training on behavioural issues is regularly assessed.²¹¹
146. In 2021, the Inspector-General of the ADF found that ‘there is no culture of evaluation in the ADF’, and that critical training relating to sexual misconduct in the ADF has not been the subject of evaluation.²¹²
147. Despite these previous findings, we acknowledge that the ADF does now engage in varying degrees of assessment and evaluation of its training programs.²¹³ According to Defence, evaluation is a key component of its cyclical ‘Systems Approach to Defence Learning’ for continuous improvement.²¹⁴ The other elements of this approach are analysis, design, development and implementation.²¹⁵

148. In statements we received from Defence in the course of our inquiry, commanding officers referred to a range of mechanisms the ADF now uses to evaluate its training programs.²¹⁶ These include quality assurance processes, learning reviews following the completion of courses, facilitator reviews, various briefings, interviews and survey instruments, and formal oversight committees, known as Learning Review Boards.²¹⁷
149. While these various mechanisms may be effective in assessing members' experience of the training, members' understanding of the course materials and the instructor's adherence with Defence policy, they cannot show whether or not the training has resulted in members' changing their behaviour or applying the learnings in their day-to-day service life.²¹⁸
150. In this way, these mechanisms individually and collectively fall short of what the Kirkpatrick Evaluation Model calls 'level 3 evaluation'. The Kirkpatrick model is the internationally recognised method for evaluating the effectiveness of training programs and is expressly referred to in Defence documents.²¹⁹ Level 3 evaluation, as Defence describes it, enables an organisation to assess 'the application of the learning in the workplace'.²²⁰ It could be argued that level 3 evaluation measures the only outcome of training that truly matters; that is, its application.
151. In the case of Defence's e-Learning modules, Defence has told us that it primarily uses member feedback at the course level to evaluate its programs (which represents level 2 under the Kirkpatrick model).²²¹ This indicates that Defence has not evaluated and therefore simply cannot know whether or not members are applying the learnings of this training in their day-to-day service life. Further, Defence has acknowledged the importance of evaluating sexual misconduct training at levels 3 and 4 of the Kirkpatrick model.²²² (Level 4 of the Kirkpatrick model evaluates 'the degree to which targeted outcomes occur as a result of the training'.)²²³ However, as of May 2024, the evaluation model was still being implemented with only levels 1 and 2 complete.²²⁴
152. In the absence of meaningful evaluation, Defence cannot know whether its training is making a real difference to members' behaviour and therefore to ADF culture. Further, it has no way of knowing whether there have been any 'unintended, undesirable consequences' from its behavioural training.²²⁵
153. We mention this because we have learnt from previous inquiries and academic literature that when poorly executed, behavioural training can actually have the *opposite* effect to that which is intended.²²⁶ Rather than catalysing a shift in problematic attitudes and decreasing incidents of unacceptable behaviour, poorly implemented behavioural training can actually strengthen those attitudes and further entrench those behaviours.²²⁷ This occurs for a number of reasons. According to the Respect@Work report, when sexual harassment training is poorly conceived and/or delivered, it can lead to the:
- reinforcement of stereotypes and generat[e] backlash by men against women (with this effect strongest among men committed to traditional gender norms). One study suggested that this backlash may arise because conventional sexual harassment training may make some men feel threatened and afraid they will be subject to false accusations, and as a result they may respond in a defensive manner.²²⁸

154. Feedback from serving members indicates that this represents a real risk for the ADF.²²⁹ While effective behavioural training can and must be part of a broader program of cultural and behavioural change, in the absence of meaningful evaluation, Defence cannot say for sure whether the training has been applied.²³⁰ As Defence's rates of unacceptable behaviour have remained stubbornly high and unchanged, we suggest that the training provided may be ineffective.²³¹

9.5.4 Preventing unacceptable behaviour

155. Defence has provided to us many statements, policies and directives in which a commitment to preventing unacceptable behaviour is stated front and centre.²³² Then Chief of the Defence Force (CDF), General Angus Campbell said:

In my roles as CDF and Chief of Army, my focus is and was on ensuring ADF personnel uphold our Values and Behaviours as a cornerstone of military capability. This included inquiring when these values and behaviours may have been compromised. I have instigated reforms to further a more positive culture and prevent unlawful and unacceptable behaviour.²³³

156. According to the Complaints and Alternative Resolution Manual (CARM), 'all Defence personnel have a role in preventing and resolving unacceptable behaviour'.²³⁴ Defence policy also requires supervisors to take 'all reasonably practicable action to prevent unacceptable behaviour in the workplace'.²³⁵
157. We also see a clear statement of intent in CA [Chief of Army] Directive 03/21, Bystander Behaviour. This January 2021 directive from the then Chief of Army requires Army members to 'take all reasonable steps available to prevent inappropriate conduct from occurring or continuing'.²³⁶

Improving bystander behaviour

158. Throughout our inquiry, we have heard how important 'bystander behaviour' is to the success or failure of initiatives designed to address and prevent unacceptable behaviour in the workplace.²³⁷ To understand this, we need to elucidate some of the underlying dynamics of military abuse.
159. In the words of Major General Orme, there are often 'strong sanctions for deviations' from the 'tight' military culture of 'shared identity, clear norms and role requirements and social stratification'.²³⁸ Professor Wadham and others go one step further, suggesting that such 'sanctions' include behaviours that are designed to bully, silence, harass and intimidate people (which they categorise as 'unacceptable behaviour'), as they function to strengthen the 'highly conformist' culture of military life.²³⁹
160. Within these dynamics, members who witness unacceptable behaviour and do not speak up act as enablers of these dynamics. Professor Wadham and others write:

There are usually dominant characters who take it upon themselves to police [the cultural orthodoxy] and there is a cadre of abusers and bystander enablers.²⁴⁰

161. As such, members who witness unacceptable behaviour either enable that behaviour through their silence or disrupt it by speaking up.
162. According to the Respect@Work report, ‘prevention techniques that encourage bystanders to take action show promise in the prevention of violence against women’, particularly when these techniques are coupled with ‘organisational development strategies’ and a clear understanding that leaders and managers are ultimately responsible for creating safe workplaces.²⁴¹
163. For the Army, members who witness unacceptable behaviour are *required*, under order of the Chief of Army, to take action and not be bystanders. A January 2021 directive requires all Army members to ‘take all reasonable steps available’ to prevent any ‘incident or situation that is a serious contravention to our values ... has an adverse impact on morale, wellbeing or discipline or which compromises Army’s reputation or capability’.²⁴²
164. Under the directive, Army members are responsible for:
- intervening, where safe to do so, to prevent unacceptable behaviour
 - reporting incidents of unacceptable behaviour they witness or become aware of
 - empowering fellow Army members to intervene in and report incidents of unacceptable behaviour.²⁴³
165. For commanders at all levels, the mandate extends to creating an environment in which members feel safe and supported to prevent and report incidents of unacceptable behaviour.²⁴⁴
166. Failing to uphold this order may result in disciplinary and/or administrative action.²⁴⁵ Former Chief of Army, Lieutenant General Rick Burr AO DSC MVO told us that disciplinary measures based on this directive have occurred, and members have left the Army as a result of failures to uphold it.²⁴⁶ Conversely, members who uphold the directive may be rewarded for doing the right thing.²⁴⁷
167. This directive was supported by the development of a new ‘Bystander Toolbox’ to ‘assist with strategic messaging, and provide resources and tools to assist command to manage incidents and educate and empower our people’.²⁴⁸
168. In October 2023, CDF [Chief of the Defence Force] Directive – 07/23 – Bystander Behaviour extended these obligations across the ADF.²⁴⁹ In the directive, the then CDF outlined his expectations that:
- all ADF members are to ACT in a way that prevents unacceptable behaviour; to REPORT inappropriate conduct when observed or knowledge is gained about; and to EMPOWER people to stop or report instances of inappropriate conduct.²⁵⁰

169. If members are given the appropriate tools to uphold such a direction, and it is accompanied by strong leadership and enforcement, we believe that this could be a meaningful mechanism for preventing and addressing unacceptable behaviour. As we discuss in Chapter 7, Culture and leadership, while the command-and-control structure of the ADF gives rise to risks that require management, this same culture can also be leveraged to create positive cultural change.²⁵¹ In this case, by creating a legal requirement for members to appropriately intervene to prevent and report unacceptable behaviour.

9.6 Complaints management

170. Over the course of our inquiry, it has become apparent that an effective complaints system is critical if members are to heal and recover from experiences of harassment, abuse and violence. Conversely, the poor management of complaints – and the silencing or further targeting of complainants – can have a significant impact on the health and wellbeing of serving and ex-serving members. As we have discussed, complaints management, particularly poor complaints management, can itself be a risk factor for suicide and suicidality.²⁵²

171. In this section, we focus on complaints mechanisms for members who experience unacceptable behaviour. Other kinds of complaints mechanisms are discussed in Chapter 10, The ADF military justice system, and Chapter 12, Role and functions of the Inspector-General of the ADF.

172. Serving members may report unacceptable behaviour for several reasons, two of which are overlapping. The reasons are as follows:

- First, they may wish for action to be taken to address the issue at the centre of the complaint; for example, action that stops the behaviour, disciplines the responsible person or people, or resolves the conflict.
- Second, they may be seeking advice and support.

173. While the focus of this section is largely on the first reason, an effective complaints mechanism should support complainants to achieve both these aims.

9.6.1 The current approach

174. In the ADF, managing complaints of unacceptable behaviour is primarily the responsibility of the chain of command.²⁵³ Because complaints are usually received, assessed and resolved by the chain of command, those in the chain of command are accountable for handling complaints effectively. This can be seen from the summary in Table 9.1, extracted from the CARM. The CARM is the ADF's 'single source document' that guides the reporting, management and resolution of complaints of unacceptable behaviour.²⁵⁴

Table 9.1 Table of complaints management process

If the complaint is about a person who is ...	The complaint is to be made to ...
in the same chain of command or line management as the person making the complaint	the complainant's commander, manager or supervisor
in a different chain of command or line management as the person making the complaint	the complainant's commander, manager or supervisor (Note: The commander or manager will then pass the complaint to the respondent's commander to manage)
the commander or manager of the person making the complaint	the person who supervises the commander or manager whom the complaint is about
unknown	EITHER: the commander, manager, or supervisor responsible for the area in which the unacceptable behaviour is alleged to have occurred OR the commander, manager or supervisor of the person who is notifying their commander of the alleged unacceptable behaviour

Note: If a complainant is not comfortable notifying the relevant commander or manager stated in the table, they may notify an alternative commander or manager in the same chain of command.²⁵⁵

Source: Exhibit 33-03.075, Hearing Block 5, Department of Defence, Response to Notice to Produce, NTPDEF-044, Complaints and Alternative Resolutions Manual, Chapter 3, Responding to unacceptable behaviour, DEF.1044.0001.0424 at 0436.

175. Not all complaints of unacceptable behaviour are handled the same way. The CARM refers to many other manuals and instructions that apply to the reporting of unacceptable behaviour. These instructions are complex and overlapping and provide different pathways, processes, levels of investigation and outcomes, depending on the type of unacceptable behaviour and the seriousness of the offence.
176. The CARM is difficult to navigate, and it can be difficult for both the person making the complaint and the person managing the complaint to determine the appropriate approach for handling different forms of unacceptable behaviour.²⁵⁶

There has been a history of poor complaints management

177. During our inquiry, we have heard many accounts of serving members (or then serving members) who wished to report violence, harassment and abuse, including sexual assault, and who faced significant barriers to doing so. We have read and heard many lived-experience accounts of a complaints system that failed to meet the needs of victims, and sometimes, failed them entirely.

178. Lived experience accounts reflect the findings of previous inquiries into violence and abuse in the ADF. In October 2011, the *Report of the Review of Allegations of Sexual and Other Abuse in Defence: Facing the Problems of the Past* found that Defence had been plagued by:

- high levels of underreporting
- high levels of dissatisfaction and disillusionment in relation to military justice
- negative outcomes as a consequence of the inconsistent application of military justice procedures.²⁵⁷

179. In its *Final Report* of March 2016, the Defence Abuse Response Taskforce (DART) found that 97% of complainants (totalling more than 1,670 complainants) who received a reparation payment from the taskforce had experienced some degree of Defence mismanagement of their complaint.²⁵⁸ Forms of mismanagement included:

- command turning a blind eye to abuse
- complainants being persuaded by command to withdraw a complaint
- command choosing not to take action, or taking insufficient action, in response to a complaint.²⁵⁹

180. Based on its responsibility for managing complaints of historical abuse, ADF Headquarters provided us with the following eight most common reasons members gave for not reporting historical cases of abuse in Defence:

- (a) The alleged abuser is in the member's chain of command. The member feels unable to go outside of the chain of command to make a report.
- (b) The member feels they would not be believed if they report alleged abuse.
- (c) The alleged abuse was witnessed by members of a higher rank who did not intervene.
- (d) The member fears retribution or further abuse from other members if they report the alleged abuse.
- (e) The member attempted to report the alleged abuse to a superior and the allegation was dismissed.
- (f) The member fears a stigma of reporting alleged abuse.
- (g) The member is unaware of other mechanisms for reporting alleged abuse, outside the chain of command.
- (h) The member believes reporting alleged abuse will have negative consequences for career progression.²⁶⁰

181. These reasons are not consistent with the assurances Defence has often provided to us about confidence in command during the course of this Royal Commission.

182. Despite these problems of the past, we have heard from the ADF that its management of complaints is much improved.²⁶¹ Various documents provided by Defence to the Royal Commission indicate that there are now high levels of confidence in the ADF and the chain of command to manage unacceptable behaviour effectively.

- In his written statement to the Royal Commission from June 2022, the then CDF General Campbell said that ‘satisfaction and overall confidence in the ADF’s management of complaints is moderate to high, while confidence in Commanding Officers management of incidents has risen’.²⁶²
- Results from a Defence-wide survey in September 2020 state that 60% of respondents agreed with the proposition ‘Incidents of unacceptable behaviour are managed well in my workplace’, and only 15% disagreed.²⁶³
- A report from the 2021–22 Inspector-General of the ADF focus group of low-ranking members that stated that:
 - 71% of those surveyed believed that the discipline process was fairly applied
 - 72% had confidence in their chain of command to resolve complaints
 - 90% felt that appropriate action would be taken in response to complaints or incidents of sexual misconduct.²⁶⁴
- The results of the Inspector-General of the ADF’s 2021 inquiry into the implementation of military justice arrangements for dealing with sexual misconduct in the ADF that reported high levels of confidence in command and the ADF in the management of sexual misconduct.²⁶⁵

183. Despite the generally positive nature of these reports, we remain concerned that many of the problems that have historically plagued the complaints system of the ADF continue to recur today.²⁶⁶ The 2023 review of Defence’s ‘Pathway to Change’ initiative paints a picture of some of its ongoing deficiencies:

Trust in the Complaints System declined for some demographic groups, particularly women in the ADF. There is some evidence of improvement in physical safety, psychosocial safety trends are mixed across incident types. Wellbeing climate indicators have remained low.²⁶⁷

184. According to the Australian Human Rights Commission (AHRC), many of the same structural and cultural barriers of the past continue to discourage or prevent members from reporting unacceptable behaviour, including:

- military cultural norms that ‘you do not jack (or dob) on your mates’; that you ‘maintain solidarity at all costs’; and ‘have each other’s backs’
- scepticism or lack of confidence that the chain of command would respond sensitively and appropriately, either because the perpetrator was of higher rank than the person reporting, or was friends with someone in the chain of command

- fear that collateral charges (such as alcohol consumption) would be made against a person who reports
- fear of negative consequences for their career, including being labelled a whistle-blower and of other reputational damage
- fear of victimisation from peers and supervisors, and of being ostracised and punished
- leaders using their authority to discourage someone from reporting
- lack of knowledge of where to go for information and support.²⁶⁸

185. The draft 'Defence Sexual Misconduct Prevention and Response Strategy', prepared in 2024 by the Department of Defence, acknowledged that the same risk factors identified by the AHRC are still a feature of the ADF environment today.²⁶⁹

9.6.2 ADF data shows that problems with complaints management remain

186. We obtained a significant volume of Defence's internal survey data to assist in gaining a better understanding of the psychosocial risks facing serving members, including their experiences of unacceptable behaviour and their confidence in the complaints management system. Additional detail about Defence's survey instruments can be found in Chapter 29, Use of data and research by Defence and DVA.

187. Between 2018 and March 2023, an average of 29% of permanent serving ADF survey participants in the Defence Workplace Behaviour survey who experienced unacceptable behaviour indicated that they made a formal complaint about the most serious incident of unacceptable behaviour. Over the same period, an average of 28% indicated that they took no action in response to the most serious incident.²⁷⁰

188. Our analysis shows that of the small proportion of victims who reported making a complaint, only 65% made that complaint to their supervisor.²⁷¹ This is concerning given Defence's reliance on the chain of command to manage complaints.

189. Among those respondents who made a complaint, satisfaction with the outcome was low. Specifically,

- less than 15% felt that a reasonable outcome was achieved
- less than a quarter reported that their complaint was resolved in a reasonable time
- just over half felt that the person who managed their complaint had sufficient knowledge to do so
- only around 30% reported being kept informed during the process²⁷²
- less than half felt that their complaint was taken seriously.²⁷³

190. Of concern to us was survey data showing differences in perceived complaint outcomes where the perpetrator was of a higher rank to the victim, compared to where the perpetrator was not of a higher rank.²⁷⁴
191. Perhaps most concerning of all is that only 11% of complainants in cases where the alleged perpetrator was of a higher rank felt that the outcome was fair.²⁷⁵ For these members, this is a radically different story to the one of 'confidence in command' that Defence has often presented throughout our inquiry.

9.6.3 Support for members who have experienced unacceptable behaviour

192. As we have already identified, unacceptable behaviour is most likely to be directed towards women, members perceived as being different, and those at certain locations or institutions within the ADF. The ADF needs to retain staff and have a healthy workforce to ensure full operational capacity. The current prevalence of unacceptable behaviour in the ADF is not compatible with maximised operational potential. Providing appropriate support for affected members can be an instrument for staff wellbeing and retention.
193. In Chapter 10, The ADF military justice system, we explore how Defence can improve the support it provides to all current serving members involved with matters of military justice, including alleged victim/survivors and perpetrators of unacceptable behaviour.
194. This section looks at the DART and the Defence Abuse Reparation Scheme that followed it in providing support or redress for historical experiences of abuse in the ADF.

Defence abuse responses and reparations

195. The DART was established on 26 November 2012 to assist complainants who had suffered sexual abuse, physical abuse, sexual harassment, and workplace harassment and bullying in Defence prior to 11 April 2011.
196. Among the range of practical outcomes available to those who made a complaint of historical abuse in Defence, the DART facilitated 'restorative engagement conference[s]' and enabled eligible personnel to access reparation payments from Defence of up to \$50,000.²⁷⁶ This provided a critical source of support and redress for serving and ex-serving members who experienced abuse in the ADF, including historical abuse.
197. Following the cessation of the DART in 2016, the Defence Force Ombudsman's role was expanded to provide an independent, confidential mechanism for serving and ex-serving ADF members to report incidences of abuse. This included the administration of the Defence Abuse Reparation Scheme. Under this version of the scheme, serving and ex-serving members who experienced abuse in Defence on or before 30 June 2014 and met the relevant thresholds for serious abuse and 'reasonable likelihood' could receive a reparation payment from Defence of up to \$50,000.²⁷⁷

198. As at 31 March 2024, the Commonwealth Ombudsman had received 4,995 complaints of abuse, and Defence had paid over \$90 million in reparation payments to serving and ex-serving members.²⁷⁸
199. In addition to reparation payments, the Defence Force Ombudsman also facilitates participation in a 'restorative engagement' program for people who reported abuse that was in the Ombudsman's jurisdiction, regardless of when the abuse occurred.²⁷⁹
200. In June 2022, the then CDF informed us that he had directed that an 'alternate mechanism' be developed to 'mitigate the closure' of the Defence Abuse Reparation Scheme. General Campbell said this new scheme would 'provide a further avenue of redress for current and former personnel who ha[d] suffered defined forms of mistreatment during their service'.²⁸⁰
201. In February 2024, General Campbell endorsed a 'concept paper' for this new mechanism.²⁸¹ Defence anticipates that the new mechanism will be implemented by 30 June 2025 and, subject to final rollouts, fully operational in 2026.²⁸²
202. According to Defence, the new mechanism will not provide financial reparation for victims of abuse 'but may have capacity to on-refer to appropriate compensatory mechanisms', such as a civil claim against the Commonwealth or through the *Compensation for Detriment Caused by Defence Administration* process.²⁸³ The new mechanism will seek to:
- embed restorative engagement into the ADF's broader complaints management processes, allowing victim-survivors to share their lived experiences and have this acknowledged by Defence²⁸⁴
 - make restorative engagement available to a broader cohort of serving and ex-serving members²⁸⁵
 - focus on contemporary, rather than historical, cases of mistreatment²⁸⁶
 - initiate a Defence-led scheme, as distinct from the Commonwealth Ombudsman-led scheme.²⁸⁷
203. There is much to recommend in this new mechanism. Feedback from both complainants and ADF leaders who have participated in restorative engagement have largely been very positive.²⁸⁸ A 2023 review, undertaken by the Commonwealth Ombudsman, summarised the feedback provided by complainants in the immediate aftermath of a restorative engagement conference as follows:
- The majority of reportees felt that it was a very positive and constructive experience and [said] the conference was conducted in a professional and respectful manner. Many reportees said they were satisfied with the outcome with some reporting they felt a sense of 'closure' or that it would contribute positively to their recovery. Many reportees also strongly agreed that Defence meaningfully acknowledged their story of abuse, strongly agreed the Defence representative was accountable for the abuse and expressed strong disapproval for what happened.²⁸⁹

204. Although more work is required for Defence to understand the longer-term outcomes of restorative engagement processes, we are pleased to see that restorative engagement processes are being expanded to provide redress to a broader cohort of ADF personnel.
205. Many serving and former serving members who have told their story to the Royal Commission may benefit from a restorative engagement process. One such cohort includes those who were subjected to historical ADF policies that discriminated against LGBTIQ+ members, but there are many others.²⁹⁰
206. In our view, restorative engagement should be available to a broad cohort of serving and former serving members who have suffered mistreatment in the ADF and at the hands of the ADF. As part of our Royal Commission, we and our Assistant Commissioners have conducted almost 900 private sessions and heard many times how powerful it was for people to finally have the suffering they endured heard and witnessed.
207. Given that a previous inquiry found that Defence's complaints system tended to be 'adversarial rather than restorative', embedding restorative engagement into the complaints system is a positive development, and the ADF's commitment to creating 'a restorative effect' for members impacted by mistreatment is commendable.²⁹¹

9.6.4 Persistent structural and cultural barriers

208. Defence's survey data (discussed in section 9.6.2) shows us that despite what the ADF says, many members who have experienced unacceptable behaviour do not believe that the complaints system works.
209. We agree with the 2023 findings of the Commonwealth Ombudsman that there are flaws in both the design and delivery of complaints mechanisms, as well as in the systems that operate alongside them that aim to support continuous improvement.²⁹² Consequently, many of the cultural and structural barriers that have historically undermined the justice and effectiveness of the ADF complaints mechanisms continue to impact members today.
210. According to the 2022 Defence Workplace Behaviour Survey, 38% of survey participants – around half of all female respondents and a third of all male respondents – reported having experienced unacceptable behaviour in the past 12 months.
211. Former Sex Discrimination Commissioner Jenkins told us:

If complaints are handled effectively, the process can help complainants recover and give them a positive experience of the workplace. Inadequate complaint processes (including delays, poor communication and uncertain outcomes) can cause complainants additional harm. In my view, there is a need to consider not just the conduct that caused the harm, but also the potential harm that can be caused by the process that follows that conduct.²⁹³
212. We ask, if an effective complaints system can help members heal from the harm caused by unacceptable behaviour, what harm could be caused by an ineffective complaints system?

Complaints processes are still confusing and complicated

213. We acknowledge that the ADF has made a dedicated effort to simplify complaints processes and improve education and training around making and managing complaints. Many updates have been made to the CARM and its supplementary resources over the past decade and more.²⁹⁴ There have been positive developments in recent times, such as periodic improvements to the CARM, and Defence's recent commitment to incorporating restorative engagement into the complaints system.²⁹⁵

214. However, the Defence reporting ecosystem continues to be overly complicated and many longstanding concerns have been raised in previous inquiries about the challenges members face while trying to navigate complaints processes.²⁹⁶

215. The Commonwealth Ombudsman's 2023 inquiry explained the importance of a complaints system that is accessible to and usable by complainants, noting:

For a complaint process to be effective, the policies and procedures governing the process should be easy to use and navigate for the people using them. Complex or unclear processes not only make complaint handling more difficult for the staff assigned such responsibility, but also increase the risk of unfair or inconsistent processes and outcomes for complainants and respondents.²⁹⁷

216. In addition to the inherent complexity of the process, one submission author told us:

the CARM is too often weaponised and poorly implemented by Command ... Although the policy is fit for purpose, the implementation is not uniform and is poorly understood by ... essential parties such as Divisional Senior Sailors, Divisional Officers, and Command.²⁹⁸

217. These concerns were identified in Defence's 2018 review into complaints handling, which generated the following two key insights:

- 'The system is opaque and respondents are lost within it'.
- 'The complaints policy assumes complaints can be dealt with at the lowest appropriate level, it is ambiguous, and it fails to provide for a proportionate complaints process'.²⁹⁹

218. The review found that in 2018, it was difficult for members who had experienced unacceptable behaviour to access necessary supports and resources.³⁰⁰ The question of what these supports and resources should comprise is examined in more detail in Chapter 10. The review also found that the complaints policy 'is convoluted and fails to provide practical guidance', and said that clearer definitions, process maps and case studies should be included in the CARM.³⁰¹

219. While this review dates back to May 2018, the findings of the Commonwealth Ombudsman from December 2023 indicate that not enough has been done since then to address the problems members face in using, accessing and understanding the ADF complaints system.³⁰²

220. The Commonwealth Ombudsman identified a range of practical reasons why the problem has persisted, including:
- that there is ‘a large volume of policies and procedures’ for individuals to navigate and understand, which can vary between the three services
 - members will not always have access to Defence’s internal computer network, which collates information about the relevant complaints processes
 - while members learn about how to make and manage a complaint during Defence’s annual workplace behaviour training, this information ‘may not be front of mind when an incident occurs and the knowledge is needed most’.³⁰³
221. Different services and training establishments in Defence have developed bespoke solutions to improve members’ understanding of the complaints system and its accessibility.³⁰⁴ Examples include fliers with simple information about how to make a complaint and, in the case of the ADFA, a quick-response code posted across the training institution that takes people to a simple website.³⁰⁵ While these initiatives are encouraging, they also illustrate the absence of a consistent and coordinated approach.
222. Defence policy acknowledges that the ‘lack of information of where to go for information and support’ can discourage members from making a complaint of, in this case, sexual misconduct.³⁰⁶
223. The Commonwealth Ombudsman recommended that Defence make information about the complaints process easily accessible to all Defence personnel and consistent across the services and the Department of Defence.³⁰⁷ It also suggested publishing information on the complaints handling process, making information accessible through a single pathway and providing simple guidance on how to make a complaint about an incident of unacceptable behaviour.³⁰⁸ Along with the other recommendations of the Commonwealth Ombudsman, Defence accepted this recommendation.³⁰⁹

Problems ‘inherent’ to the chain of command

224. As we discussed in section 9.6.1 of this chapter, the ADF’s complaints system is primarily the responsibility of the chain of command.³¹⁰ We acknowledge the importance of the chain of command in this regard, and recognise its significance in maintaining order, discipline and, ideally, promoting positive behaviours and modelling and upholding exemplary workplace culture. The chain of command also provides an ‘on-the-ground’ option for complainants aimed at dealing with complaints efficiently.³¹¹
225. We would not expect, nor recommend, that the chain of command be relieved of its responsibility to manage unacceptable behaviour. However, our inquiry has found that things are not working as intended in terms of the way in which the chain of command deals with complaints. Whether it be the culture, the structure or the way in which command and control flows through the chain of command, it seems that the chain of command is a significant and enduring part of the ADF’s complaints system problem.

226. In 2020, the Inspector-General of the ADF found a significant ‘negative correlation between [members’] confidence in the chain of command taking action [on complaints] and rates of unacceptable behaviour’.³¹² This means that ‘rates of unacceptable behaviour are lower in units where personnel have confidence command will act on complaints’.³¹³ As the Inspector-General wrote in a letter to the Chief of the Defence Force (CDF):

This is likely because potential complainants feel empowered to complain about unacceptable behaviour, and because potential perpetrators believe they will face consequences. Both these factors would drive the number of unacceptable behaviour incidents down.³¹⁴

227. Historically, members have not reported incidents of unacceptable behaviour because of perceived failings associated with the chain of command – be it command involvement in the unacceptable behaviour, command implicitly or explicitly condoning the behaviour and/or command failing to deal appropriately with a complaint.³¹⁵ This is evident from the reasons provided by ADF Headquarters about why members did not report cases of historical abuse (see section 9.6.2).³¹⁶

228. In one submission, a current serving member wrote that nearly everyone they knew had experienced some form of unacceptable behaviour but that people are afraid of the consequences of reporting it.³¹⁷

229. Former Sex Discrimination Commissioner Jenkins also recognised that these problems are entrenched and largely unresolvable because the complaints mechanism relies on the chain of command.³¹⁸ The Commonwealth Ombudsman described these as ‘inherent problems’ of reporting within the chain of command because, in the words of someone with lived experience, the same people ‘are responsible for both your future and, often, the future of the people you are complaining about’.³¹⁹

230. Although steps can and should be taken to improve the management of complaints made through the chain of command, even the most effective version of this system would not be free of these issues. Victims of unacceptable behaviour will fear reprisal and may never wholly trust that those responsible for managing their complaint will do so in a fair, confidential and impartial manner – whether or not that distrust is reasonably founded. We have found that these problems are not only related to a structural issue (that is, the way in which complaints are managed), they are also compounded by enduring cultural issues across the ADF.³²⁰

Ensuring complaints are handled appropriately and consistently

231. Poor complaints management may not necessarily be attributable to a deficiency in policy, it may be more attributable to the way it is implemented and interpreted. This can lead to poor outcomes for members who experience unacceptable behaviour.

232. Previous inquiries into the matter revealed that Defence's complaints handling system was of variable quality depending on which commander or manager was dealing with the complaint.³²¹ As these previous inquiries discussed, this variability could be due to insufficient training, human error, a lack of experience, incompetence or, in some cases, 'commanders and managers ... [being] part of the problem'.³²²
233. The Commonwealth Ombudsman attributed this to 'a lack of quality controls and quality assurance built into Defence's complaint handling framework'.³²³ The report states that robust forms of internal quality control are particularly critical for an organisation like Defence 'where complaint handling is decentralised ... with many people from different services and units responsible for [it]'.³²⁴
234. To address this problem, the Commonwealth Ombudsman recommended that Defence develop a framework that:
- provides assurance that complaints are being handled in accordance with Defence's complaint handling framework
 - ensures consistency in approach across the services and the Department of Defence, including by introducing internal and centralised oversight
 - has a built-in regular review process to ensure quality controls and quality assurance are achieving the desired outcomes and are updated to address any emerging issues or areas of risk in compliance.³²⁵
235. Defence has accepted this recommendation, and as at May 2024, it had begun to implement it.³²⁶

9.6.5 Poor record keeping and data management

236. Record keeping is critical to Defence's ability to track and monitor incidents of unacceptable behaviour and to ensure that complaints are handled efficiently, effectively and with due care for all members.³²⁷
237. Defence's record-keeping system is fragmented and comprises several standalone systems, of which the principal systems are ComTrack, Sentinel, and the Defence Policing and Security Management System.³²⁸ When recording a complaint or incident, managers often have to navigate and input data into several systems, leading to data duplication, wasted effort and a high risk of human error.³²⁹ Dispersing key information across several systems also limits the accurate reporting of the prevalence of events, undermines data analysis to identify themes and trends, and impacts due diligence in ensuring the effective management of complaints.
238. The ADF's inadequate record keeping has been a common and enduring theme across the Inspector-General of the ADF's military justice performance audits (as discussed in more detail in Chapter 10, The ADF military justice system).³³⁰ Similarly, the Commonwealth Ombudsman undertook its own review of ADF complaints records in 2023 and found that they 'varied significantly in the level and quality of detail provided'.³³¹ Despite this, we have heard that limited attention is paid to the analysis of systemic trends and to seeking opportunities for improvement.³³²

239. Defence has been working on a new whole-of-Defence case management system for more than 20 years.³³³ This single system would replace the several standalone, ‘stove-piped’ data systems, and record and track complaints and incidents, and gather data on how these complaints and incidents are managed.³³⁴ Defence’s new Case Management System (Case), including its potential deficiencies, is discussed in Chapter 10. As at May 2024, the Case Management System was scheduled to be released in mid-2024.³³⁵
240. An interrelated solution offered by Defence is to integrate ‘all unacceptable behaviours reporting elements from across Defence into one dashboard interface, tailored for Groups and Services reporting’.³³⁶ According to the Associate Secretary of the Department of Defence, Matthew Yannopoulos PSM, the new ‘interface’ would support Defence to ‘drill-down’ into its complaints data and undertake ‘longitudinal analysis of unacceptable behaviour’.³³⁷ However, as we explore in Chapter 8, Military sexual violence, there are a range of ongoing barriers that would need to be overcome for this to be a success, including longstanding challenges related to sharing and consolidating data on unacceptable behaviour.³³⁸

9.6.6 Learning from best practice

241. Recent social movements signalling a shift in community attitudes to standards of conduct have shone a spotlight on workplace culture across Australia. A number of important reviews of workplaces outside Defence have been conducted, including the AHRC report on sexual harassment in Australian workplaces (Respect@Work) and Commonwealth Parliamentary workplaces (Set the Standard).³³⁹
242. The AHRC has engaged in a unique collaboration with Defence since 2016 to help guide cultural reform. Learnings from this work in relation to the principles that apply to modern-day reporting and the investigation of complaints of unacceptable behaviour are invaluable.
243. A system in which unacceptable behaviour is prevented or avoided in the first place is far better than one that responds to incidents once they have occurred.³⁴⁰ Further, an effective complaints reporting system must fit within the broader organisational ecosystem and its culture. It must not be viewed as a standalone solution if it is to reduce and eventually prevent incidents of unacceptable behaviour.
244. The AHRC’s Set the Standard report describes best practice in the reporting and management of complaints of unacceptable behaviour. The report states:
- [t]aking a person-led approach when responding to reports and complaints of workplace misconduct can increase the confidence and willingness of people to report/complain. It can also avoid or reduce the possibility of harming or re-traumatising people who have experienced misconduct.³⁴¹

245. The report identifies other key elements and features, including:
- providing ongoing trauma-informed support throughout the process
 - protecting complainants from further victimisation
 - strengthening a safe reporting culture
 - providing flexible reporting options.³⁴²
246. Other bodies and inquiries have developed similarly clear guidelines as to how a best-practice complaints mechanism should operate.³⁴³ One standout is the Victorian Equal Opportunity and Human Rights Commission's (VEOHRC) five-year review into sex discrimination and sexual harassment at Victoria Police.³⁴⁴ There is much Defence can learn from the VEOHRC's review, particularly given the many cultural and structural parallels between the ADF and police services.³⁴⁵

9.6.7 Building a more effective complaints system

247. If a member does not feel that they can approach their chain of command with a complaint, there are a range of potential options outside the chain of command, both internal and external to the Defence enterprise, to which the ADF may direct members. These include the AHRC, the Defence Force Ombudsman, the Inspector-General of the ADF (IGADF), the Office of the Australian Information Commissioner, the Public Interest Disclosure Scheme, the Joint Military Policing Unit (JMPU), and the civilian police.³⁴⁶

Limitations of mechanisms for reporting unacceptable behaviour outside the chain of command

248. While listed as avenues for complaint, none of these options adequately address, or indeed are intended to address, complaints of unacceptable behaviour. There is currently no comprehensive complaints mechanism available to members for managing first-instance complaints of unacceptable behaviour outside the chain of command.

The Australian Human Rights Commission

249. Serving members who believe they have experienced unlawful discrimination, sexual harassment and/or breaches of their human rights can make a complaint to the AHRC.³⁴⁷ However, the AHRC is 'not a court and does not have the power to decide if what you are complaining about is unlawful discrimination'.³⁴⁸ It also does not cover all types of unacceptable behaviour.³⁴⁹
250. The Complaints and Resolutions Manual (CARM) encourages members to pursue other avenues for complaints before they contact the Australian Human Rights Commission (AHRC).³⁵⁰ The AHRC handles complaints by conducting an investigation, which includes speaking with the relevant parties and then engaging in a process of conciliation.³⁵¹ Outcomes may include an apology, compensation, and training and/or practical changes to facilities and services.³⁵² Depending on the facts of the complaint, either an individual or Defence as an organisation may be found responsible.³⁵³ This process does not facilitate disciplinary action for any wrongdoing, and the AHRC does not facilitate referrals to a military justice agency or to police for further action in relation to a complaint.³⁵⁴

The Defence Force Ombudsman

251. Since December 2016, the Defence Force Ombudsman has provided an independent, confidential mechanism for serving and ex-serving ADF members to report incidents of sexual abuse, serious physical abuse, and serious bullying and harassment involving two or more Defence personnel.³⁵⁵ Their jurisdiction is limited by the definition of 'abuse', which does not cover all forms of unacceptable behaviour, and is subject to temporal constraints, meaning that historical incidents may not be covered.³⁵⁶
252. The Defence Force Ombudsman supports eligible complainants by facilitating access to counselling, using an alternative dispute resolution process or a restorative engagement process to address or resolve the complaint. The Ombudsman can make recommendations to the Department of Defence in respect of the complaint. The Ombudsman can also inquire into the effectiveness and appropriateness of Defence's procedures and can refer evidence of a complaint to police or a military justice agency for investigation and potential prosecution.³⁵⁷ However, it cannot *investigate* incidents of unacceptable behaviour, it cannot mandate disciplinary or criminal action, and the assessment of claims can take over 18 months.³⁵⁸

The Inspector-General of the ADF

253. The CARM sets out the matters upon which submissions can be made to the IGADF concerning military justice.³⁵⁹ Unacceptable behaviour is consistently the most common form of complaint made to the IGADF, and made up 39% of all complaints in the 2021 to 2022 period.³⁶⁰ The IGADF states that between 8% and 10% of complaints are 'resolved' at the assessment phase.³⁶¹ However, that does not mean they have been resolved to the satisfaction of the complainant.³⁶²
254. If a submission does proceed to an inquiry, a report is prepared that includes findings and recommendations; however, these are not binding.³⁶³ Some members turn to the IGADF as a first-instance complaints mechanism.³⁶⁴ However, the IGADF told us that 'unless a complainant expresses a loss of faith in the entire Service Chain of Command, generally the IGADF prefers the Service to attempt to resolve the matter'.³⁶⁵

The Office of the Australian Information Commissioner

255. The Office of the Australian Information Commissioner is an independent statutory agency that upholds Australia's Privacy Laws as set out in *Privacy Act 1988* (Cth). The Information Commissioner does not investigate general reports of unacceptable behaviour. The remit of the Commissioner is confined to complaints about the handling of personal information by an Australian Government agency or other large organisation.
256. Members may make a complaint about the mishandling of their personal information by Defence. However, to make a complaint, they are first expected to have attempted to resolve the matter internally within Defence.

The Public Interest Disclosure Scheme

257. The Public Interest Disclosure (PID) scheme, established by the *Public Interest Disclosure Act 2013* (Cth) (the PID Act), promotes integrity and accountability in the public sector, and is effectively a ‘whistle-blower’ scheme for the Commonwealth. The CARM states that a person who believes on reasonable grounds that an incident of unacceptable behaviour may be ‘disclosable conduct’ under the PID Act may notify their commander or manager or an authorised officer.³⁶⁶
258. The PID scheme is limited by what is defined as ‘disclosable conduct’. Amendments to the scheme that came into effect in 2023 considerably reduce the scope of conduct captured by this definition.³⁶⁷ This means that members wanting to complain of ‘personal work-related conduct’, which can include but is not limited to bullying and harassment, may no longer be afforded protection under the PID Act.³⁶⁸

The Joint Military Policing Unit and civilian police

259. While the JMPU works with the chain of command to exercise its functions, it is expected to operate independently of command influence, particularly with respect to its investigative functions.³⁶⁹ The JMPU supports Defence by assessing notifiable incidents, including incidents in which there is reasonable suspicion that a criminal offence may have been committed under the *Defence Force Discipline Act 1982* (Cth), among a range of other types of serious incidents.³⁷⁰ Less serious disciplinary matters are often referred to the chain of command to be resolved.³⁷¹
260. Members may also report unacceptable behaviour, which may constitute a criminal offence, to a civilian police force of a state or territory. Defence’s ‘Incident Reporting and Management Manual’ states that nothing in the manual is intended to prevent members from reporting suspected criminal offences directly to civilian police.³⁷² However, not all incidents of unacceptable behaviour meet the threshold of a criminal offence. These systems are discussed further in Chapter 10.

Ensuring the effectiveness of reforms to the complaints system

261. As previously stated, we support the recommendations of the Commonwealth Ombudsman made in 2023. In our opinion, the most significant recommendation addresses the need for a new complaints mechanism outside the chain of command. The Commonwealth Ombudsman recommended that Defence ‘create, or task an existing area with being, a centralised and specialised unit to oversee the complaint handling process Defence-wide’.³⁷³ The Commonwealth Ombudsman also recommended that this mechanism should provide members with a reporting option outside the chain of command and support continuous improvement of Defence’s complaints systems.³⁷⁴
262. In May 2024, the Commonwealth indicated that Defence will establish a ‘centralised and specialised complaint handling unit’ to mitigate known barriers to reporting unacceptable behaviour, including by giving members the ability to make complaints outside the chain of command and/or anonymous complaints.³⁷⁵ No further information was provided, and we are not able to say this fills us with confidence.

263. We remain concerned that these recommendations, like others that have come before, could be improperly or ineffectively implemented, meaning that the anticipated outcomes are never realised.
264. Defence's failure to implement inquiry recommendations effectively is a significant and recurring problem that we have examined throughout this report, including in the context of complaints management.³⁷⁶ For example, Defence acknowledged that there had been significant delays in implementing the recommendation of the interim National Commissioner for Defence and Veteran Suicide Prevention to create a mechanism for reporting unacceptable behaviour outside the chain of command.³⁷⁷
265. Close to three years later, Defence began the process of implementing the recommendations of the Commonwealth Ombudsman's 2023 inquiry, including a recommendation that is 'largely the same' as that of the interim National Commissioner.³⁷⁸ However, we acknowledge the Australian Government never formally responded to the National Commissioner's recommendation.³⁷⁹
266. Defence should instigate a two-stage external evaluation process to ensure that implemented recommendations are achieving the Commonwealth Ombudsman's and the Royal Commission's desired outcomes. The two stages comprise:
- Stage 1: Twelve months after the purported implementation of the Commonwealth Ombudsman's recommendations (in late 2025 or early 2026) an external audit should be undertaken of Defence's implementation of all of the Commonwealth Ombudsman's recommendations. Both the Commonwealth Ombudsman and the AHRC have undertaken audits of this kind. These audits have been very useful to the work of the Royal Commission, and have helped us to hold Defence accountable for implementing inquiry recommendations.³⁸⁰
 - Stage 2: In relation to the Commonwealth Ombudsman's most significant recommendations, notably Recommendation 3 and its supplementary recommendations, an independent outcomes evaluation should be commissioned once these recommendations have been operational for a suitable amount of time, likely a further 12 to 18 months after Stage 1. Based on this final report, the Commonwealth Ombudsman's report and the literature on best-practice complaints management, the evaluator should determine what outcomes must be assessed to determine the overall effectiveness of Defence's implementation.³⁸¹ These outcomes may include but should not be limited to improvements in:
 - the rates of underreporting
 - member confidence in the complaints system
 - reports of psychosocial safety.
 - The outcomes evaluation, and Defence's response to that evaluation, should be provided to the appropriate minister or ministers for their consideration.

267. Multi-stage evaluation processes are commonplace in the implementation of significant reforms. Defence itself has indicated that it plans to measure the effectiveness of its implementation of the Ombudsman's recommendations.³⁸² Further, Associate Secretary Yannopoulos acknowledged the value of a robust outcomes evaluation of Defence's implementation of these recommendations.³⁸³
268. Our hope is that this will support continuous improvement and contribute to Defence making meaningful improvements to a complaints system that, despite years of tinkering and reform, continues to fail serving members who have experienced unacceptable behaviour.

Identifying and acting on hot spots

269. In addition to a more effective complaints system, Defence must also proactively observe the organisation for signals of unacceptable behaviour, regardless of whether the unacceptable behaviour is formally reported.
270. In section 9.2.3 and Chapter 29, Use of data and research by Defence and DVA, we note how the United States uses survey data to categorise military sites as low- or high-risk locations for sexual assault, harassment and suicide.³⁸⁴ The data from these sites provides insights into risk and protective factors, and is being used to improve efforts to reduce sexual assault, harassment and suicide in the military.³⁸⁵ Defence told us that this process is a 'best-practice practical activity' and that its application to ADF sites warranted consideration.³⁸⁶
271. Drawing on this model, we recommend that Defence use a range of administrative and survey data sources to identify and act on hot spots of unacceptable behaviour. If Defence is serious about addressing unacceptable behaviour, it cannot simply rely on periodic audits conducted by the IGADF to identify locations at which misconduct has gone unchecked. Lieutenant General Stuart acknowledged that, in his view, there is a need for improved and more timely mechanisms to identify areas of risk.³⁸⁷
272. To ensure transparency and accountability to ADF members, Defence should publicly report on hot spots and actions taken to address unacceptable behaviour in those sites. Reporting should be structured to ensure privacy and the careful management of sensitive information, especially for small cohorts.
273. In Chapter 10, The ADF military justice system, we consider the importance of proactive monitoring as part of military justice governance, assurance and policy. We recommend the ADF continue to define military justice metrics alongside health and wellbeing metrics that together can:
- identify and monitor risks of misuse and abuse
 - track complaints, termination trends, offences and investigations
 - identify members subject to repeated military justice processes
 - identify officers who apply disproportionately high rates of administrative sanctions.

274. Proactive monitoring to detect risks of unacceptable behaviour is a critical element of this program, and we highlight it with a dedicated recommendation in this chapter.
275. In Chapter 4, Postings and deployments, we recommend that Defence empower career managers to consider cumulative stressors experienced by members, including psychosocial risk factors, such as exposure to unacceptable behaviour, when making posting decisions. Reporting on hot spots of unacceptable behaviour should be a key input to these decisions.

Recommendation 26: Foster a strong culture of reporting unacceptable behaviour

Defence should foster a strong reporting culture to:

- (a) proactively identify at-risk locations, cohorts, ranks or roles where toxic subcultures are flourishing
- (b) implement risk mitigation strategies to address unacceptable behaviour directly in the locations, cohorts, ranks or roles identified
- (c) report publicly on identified hot spots of unacceptable behaviour and what actions have been taken to address unacceptable behaviour.

Recommendation 27: Evaluate outcomes to ensure that Defence has addressed the intent behind recommendations

Defence should evaluate the outcomes of actions taken to implement the recommendations made by the Commonwealth Ombudsman in its review *Does Defence handle unacceptable behaviour complaints effectively? Defending Fairness*, to ensure that the intent of the recommendations is achieved.

9.7 Conclusion

276. The ADF is a unique and often insular workplace. Members may spend nearly 24 hours a day in close proximity to each other, living, working and even sleeping side-by-side. We have heard accounts of members in diverse situations in the ADF, including those living in remote locations and confined spaces, who have suffered violence and abuse from fellow members who should have been supportive friends, colleagues and/or supervisors.

277. Defence workplaces can be challenging, and these challenges are compounded by certain aspects of military culture, which we have explored here and in Parts 2 and 3 of our final report. Certain cultural norms that persist in Defence mean that having a robust complaints mechanism outside the chain of command is critical. Sadly, a high percentage of current and former serving members have been subjected to harassment, violence and abuse.
278. Many members who have experienced and reported unacceptable behaviour have lost faith in the complaints handling systems of the ADF. As things currently stand, even the most effective version of a complaints mechanism that relies on the chain of command cannot be free of the dynamics that cause victims to fear reprisals for reporting an incident and to distrust the system responsible for the management of their complaint.
279. Defence has attempted to build safe and effective complaints mechanisms throughout much of its history. In recent years, we have seen numerous reviews and inquiries that have attempted to rebuild and reshape Defence's internal complaints mechanisms. However, time and time again, these mechanisms have failed, and members are still suffering as a result.
280. If Defence wishes to have a fully operational defence force, it simply must provide its members with a working environment that is as physically and psychologically safe as possible, recognising the inherent dangers of service life. Without this, there is no way that the ADF will ever again become an employer of choice. The alarming proportion of ADF serving members who have experienced unacceptable behaviour demonstrates that existing initiatives are not sufficient to manage the problem. In this context of consistent failure, we believe that a more transformational change is necessary.

Endnotes

- 1 Appendix L, Defence survey data.
- 2 Defence Abuse Response Taskforce, *Report on Abuse in Defence*, Progress Report, November 2014 (Exhibit 26-02.006, Hearing Block 4, EXP.0004.0010.0009); GA Rumble and others, *Report of the Review of allegations of sexual and other abuse in Defence: Facing the problems of the past, General findings and recommendations*, October 2011, vol 1 (Exhibit 17-03.017, Hearing Block 3, EXP.0003.0010.0319); B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, pp 47–75 (Exhibit F-01.061, DVS.0011.0001.1192); Transcript, Danielle Wilson, Hearing Block 3, 8 March 2022, pp 17-1471 [41]–17-1476 [7]; Transcript, Nikki Coleman, Hearing Block 11, 29 August 2023, pp 77-7437 [24]–77-7439 [9]; 77-7443 [34]–77-7468 [34]; Transcript, Paul Morgan, Hearing Block 12, 21 March 2024, pp 97-9750 [1]–97-9792 [6].
- 3 B Wadham and J Connor, 'Commanding Men, Governing Masculinities: Military Institutional Abuse and Organizational Reform in the Australian Armed Forces', *Gender, Work & Organization*, vol 30, 5, 2023, p 2 (Exhibit 101-03.132, Hearing Block 12, DVS.0012.0001.3708).
- 4 B Wadham and J Connor, 'Commanding Men, Governing Masculinities: Military Institutional Abuse and Organizational Reform in the Australian Armed Forces', *Gender, Work & Organization*, vol 30, 5, 2023, p 6 (Exhibit 101-03.132, Hearing Block 12, DVS.0012.0001.3708).
- 5 M MacKenzie and others, 'Illicit Military Behaviour as Exceptional and Inevitable: Media Coverage of Military Sexual Violence and the "Bad Apples" Paradox', *International Studies Quarterly*, 64, 1, p 47 (Exhibit 17-03.05, Hearing Block 3, EXP.0003.0010.0039).
- 6 Royal Commission into Defence and Veteran Suicide, *Interim Report*, August 2022, pp 107–112.
- 7 Royal Commission into Defence and Veteran Suicide, *Interim Report*, August 2022, pp 112–115.
- 8 B Wadham and others, *Mapping Service and Transition to Self-Harm and Suicidality*, commissioned by the Royal Commission into Defence and Veteran Suicide, August 2023, p 47 (Exhibit F-01.061, DVS.0011.0001.1192).
- 9 Exhibit 35-02.002, Hearing Block 5, Chief of the Defence Force, General Angus Campbell, Response to Notice to Give, NTG-ACA-001, DEF.9999.0011.0344 at 0435.
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10 The ADF military justice system

Summary

A well-functioning military justice system is essential for Defence to maintain good order and effective operational control. It is equally crucial to the mental health and wellbeing of Australian Defence Force (ADF) members.

Our inquiry has identified failings within the military justice system that have the potential to damage the wellbeing of and contribute to suicide and suicidality among serving and ex-serving members. This chapter examines key elements of the military justice system, and identifies reforms to key governance, risk management and assurance mechanisms to overcome oversight failings inherent throughout the military justice system.

The military justice system is highly complex. It primarily comprises a discipline system and an administrative system, both of which require the processes and outcomes of the military justice system to be:

- clear and consistently applied
- transparent and procedurally fair
- supportive of both the accused and any victims.

The consequences of poor administration of the military justice system can be devastating for individual members. It undermines trust in the integrity of the system at each of the unit, service and enterprise levels.

Data we obtained shows that ADF members who have been involved in the military justice system are at an increased risk of suicide. That is particularly the case for members whose service is terminated under regulation 24(1)(c) of the *Defence Regulation 2016* (Cth) for the reason that 'retention of the member's service is not in the interests of the Defence Force'.¹

The administrative system poses unique and significant risks. It relies heavily on the discretion of command who must also balance operational demands and tactical matters. Behaviour that may attract attention under the military justice system can also be an indicator of underlying mental health issues. The evidence and information presented to us is that command is ill equipped to consistently identify, manage and respond to these issues.

Defence's governance, oversight and safeguards fail to provide the necessary oversight to manage failings and risks within the military justice system. Those in senior leadership positions have limited visibility of patterns or trends because data sources are fragmented and poorly maintained, as highlighted in Chapter 29, Use of data and research by Defence and DVA. That leaves the administrative justice system vulnerable to abuse and misuse; simply put, there is no transparency around the application of administrative sanctions.

The military justice system has no formalised risk management framework. It lacks meaningful analysis to identify, reduce or mitigate risk factors that negatively impact on the mental health and wellbeing of members. Any risk identification and management occurs in an ad hoc manner and senior leaders make decisions regarding the allocation of people to tasks and projects in the absence of appropriate risk assessment.

As it stands, Defence as an organisation cannot identify emerging issues within the military justice system with any consistency or reliability.

It has developed the Enterprise Resource Management case management system (CASE) and the Military Justice Assurance Framework to address these issues. However, progress on both has been unacceptably slow and they only offer a partial solution to the problem. Its attempt to draw on existing data sources to implement an interim strategy for monitoring and risk management has been limited and ad hoc.

There needs to be a more systemic approach to providing good quality legal and wellbeing supports.

Recently Defence has made some improvements to its trauma-informed policy and provided a stronger focus on wellbeing through its military justice system. However, administrative efforts alone do not translate to meaningful, long-term change.

Our recommendations are directed to bringing about a more rigorous military justice system. They include:

- enhancing the training and guidance provided to command to embed procedural fairness into their decision-making
- monitoring and responding to risks inherent in military justice through external review and improved data collection, integration and analysis
- improving supports to members involved in a military justice matter by providing timely information, legal assistance, minimum standards regarding information provision and access to support and automatic 'opt out' referral to mental health supports.

Key to strengthening governance and assurance mechanisms and systems, is that ADF must find a well-resourced 'home' to coordinate and advance the matters set out above.

10.1 Introduction

1. This chapter explores the operation of the military justice system as it relates to the risk of suicide and suicidality, and health and wellbeing outcomes. In this chapter, we consider how enhancing safeguards and improving governance and assurance arrangements can reduce or remove risk factors that contribute to suicide and suicidality amongst serving and ex-serving members.
2. ADF members live, work, train and deploy to operational environments together. An effective and efficient system to manage adverse behaviours is critical to maintain the morale, wellbeing and discipline of a military force capable of fighting wars.² The military justice system needs to support the ADF to have members capable of using force within the ADF's ethical and lawful framework when deployed.³ It does so through a set of legislative and regulatory rules, tools and processes, that command uses to maintain operational control and effectiveness.⁴
3. This system is self-regulating and enforces its own code of ethics.⁵ Defence is a 'profession of arms' in which serving members 'each share in offering unlimited liability' and are willing to put service before self as a part of military duty:

Unlimited liability means that each member of the ADF not only offers their own life, if needed, in exercising lawful and appropriate force, but trusts in those with whom they serve to do the same.⁶

4. Critically, Defence recognises that:

Those who make military justice decisions are also offering service on an equal footing with others, and therefore share personally in the costs and risks of their decisions.⁷

5. ADF members accept the 'centrality of command', and Defence sees the military justice system as having a key role in it:

The gravitas of command, and obedience to it, are built during peace time, including through trust in the chain of command to manage discipline fairly and justly, to make lawful and just administrative decisions and to deal fairly with grievances. At the same time, the ADF military justice system is a function of command, which has ultimate responsibility for the discipline, order and effectiveness of the ADF as a military force.⁸

6. In Hearing Block 12, the then Vice Chief of Defence, Vice Admiral David Johnston, explained members must submit to the military justice system as an inherent requirement of service:⁹

Because the justice system is part of the command function. It is a relationship between a commander and the people they are leading and commanding. It reinforces command by the application of justice to it. It's critical to us because it deploys with us, so it is extraterritorial in its nature where not many other elements of our domestic system are, so it is a core ingredient.¹⁰

7. However, it carries an inherent risk, namely abuse by authority:

The ADF is a hierarchical system, where those with rank occupy positions of authority over subordinates. In hierarchical systems, the abuse of authority is an inherent risk.¹¹

8. Our inquiry found this risk is not being adequately monitored or managed. That is of particular concern due to the inherently stressful nature of military justice processes, which are often adversarial and may lead to involuntary separation.
9. We know that involuntary separation is a risk factor for suicide and suicidality. That is particularly so for termination of a member's service under *Defence Regulation 2016* (Cth) regulation 24(1)(c) for the reason that 'retention of the member's service is not in the interests of the Defence Force'.¹² See Chapter 1, Understanding Suicide, for further discussion on this.
10. We have recommended a more robust governance and assurance framework to identify and respond to risk factors in the military justice system that contribute to suicide and suicidality. Effective assurance and governance are particularly important to managing the risk of inconsistent application of the military justice system and inconsistent outcomes along with the potential for that system's misuse and abuse by those in command positions.
11. There is also room for substantial improvement in support for members engaged in the military justice system, including by adopting trauma-informed principles.
12. Finally, we note that Defence's management of unacceptable behaviour and sexual misconduct also fall within the remit of the military justice system. However, the complexity and significance of those issues have warranted separate consideration in Chapter 9, Unacceptable behaviour and complaints management, and Chapter 8, Military sexual violence. Some issues canvassed in this chapter are also mentioned in Chapter 12, Role and functions of the Inspector-General of the ADF, about the Inspector-General of the Australian Defence Force, who has oversight of the military justice system.

10.1.1 The military justice system is complex

13. The military justice system is complex. It is set out in statutes, including the *Defence Act 1903* (Cth), *Defence Force Discipline Act 1982* (Cth) (Defence Force Discipline Act), the *Defence Legislation Amendment (Discipline Reform) Act 2021* (Cth), *Defence Regulation 2016* (Cth) (Defence Regulation 2016) and *Defence (Inquiries) Regulations 2018* (Cth), as well as in Defence policies and procedures.¹³

14. It has four main components:
- (1) fact finding and administrative inquiries, conducted to determine whether an incident should be managed under the administrative or discipline system
 - (2) disciplinary investigations and proceedings under the Defence Force Discipline Act 1982
 - (3) action taken under the administrative system, including the involuntary separation of a member under the Defence Regulation 2016
 - (4) complaints, including redress of grievances.¹⁴
15. ADF's discipline system and administrative system are notably different. However, both disciplinary and administrative action can adversely impact a member's career, including through termination of their service.

The discipline system

16. The discipline system concerns action for conduct that may constitute an offence under the Defence Force Discipline Act.¹⁵ The statute's purpose is to preserve and administer military discipline and it includes offences that are distinctively military and others that occur in the military environment.¹⁶ These offences are classified as either a service offence, which is an offence against the Commonwealth, or a disciplinary infringement relating to minor disciplinary matters.¹⁷
17. The Act contains discipline options addressing service offences. These may also be criminal offending in the civilian domain. Disciplinary matters are managed through three processes:
- (1) Disciplinary infringement under the Discipline Officer Scheme. This is the lowest level for management of minor breaches by a non-commissioned rank where there is no factual dispute and the member admits the misconduct.
 - (2) Charge for a service offence before a summary authority. This is used by commanding officers and superior summary authorities to provide limited or lesser punishments.
 - (3) Charge for a service offence before a superior tribunal (a Defence Force Magistrate or a Court Martial). Magistrates are senior legal military officers.¹⁸
18. If, after some preliminary information gathering, a commander believes an incident could be a service offence, they must notify the appropriate Defence Investigative Authority (such as the Joint Military Policing Unit¹⁹), or the Inspector-General of the ADF if required.²⁰
19. The Defence Investigative Authority (DIA) will assess whether to carry out an investigation, refer the matter back to the notifying unit, or refer to a different authority. The latter could include another DIA, civilian police, or investigative authorities.²¹

20. DIA evidence may be provided to either the accused person's chain of command or directly to the Director of Military Prosecutions, who is authorised to charge a defence member with a service offence.²² The Director may decide to charge the member independently, or refer the matter back to the chain of command to make that decision for a minor matter.²³
21. Although ADF members operate under specific military law, they are also subject to civilian criminal law in relation to misconduct in Australia. Charges for service offences may be brought either under the Act or under civilian criminal law.²⁴
22. Criminal matters where civilian police have primary jurisdiction are generally referred to civilian police, or the affected individuals are encouraged to report to civilian police themselves.²⁵ For serious criminal offences committed in Australia, the civil power decides whether the offender is dealt with under military or civilian law.²⁶
23. The Joint Military Police Unit is generally responsible for investigating complex or sensitive matters of a criminal or disciplinary nature.²⁷ Examples include theft, fraud, assault, sexual offences, illicit drugs, and sudden death.²⁸ The unit is not a focus of this chapter and is covered in Chapter 8, Military sexual violence.

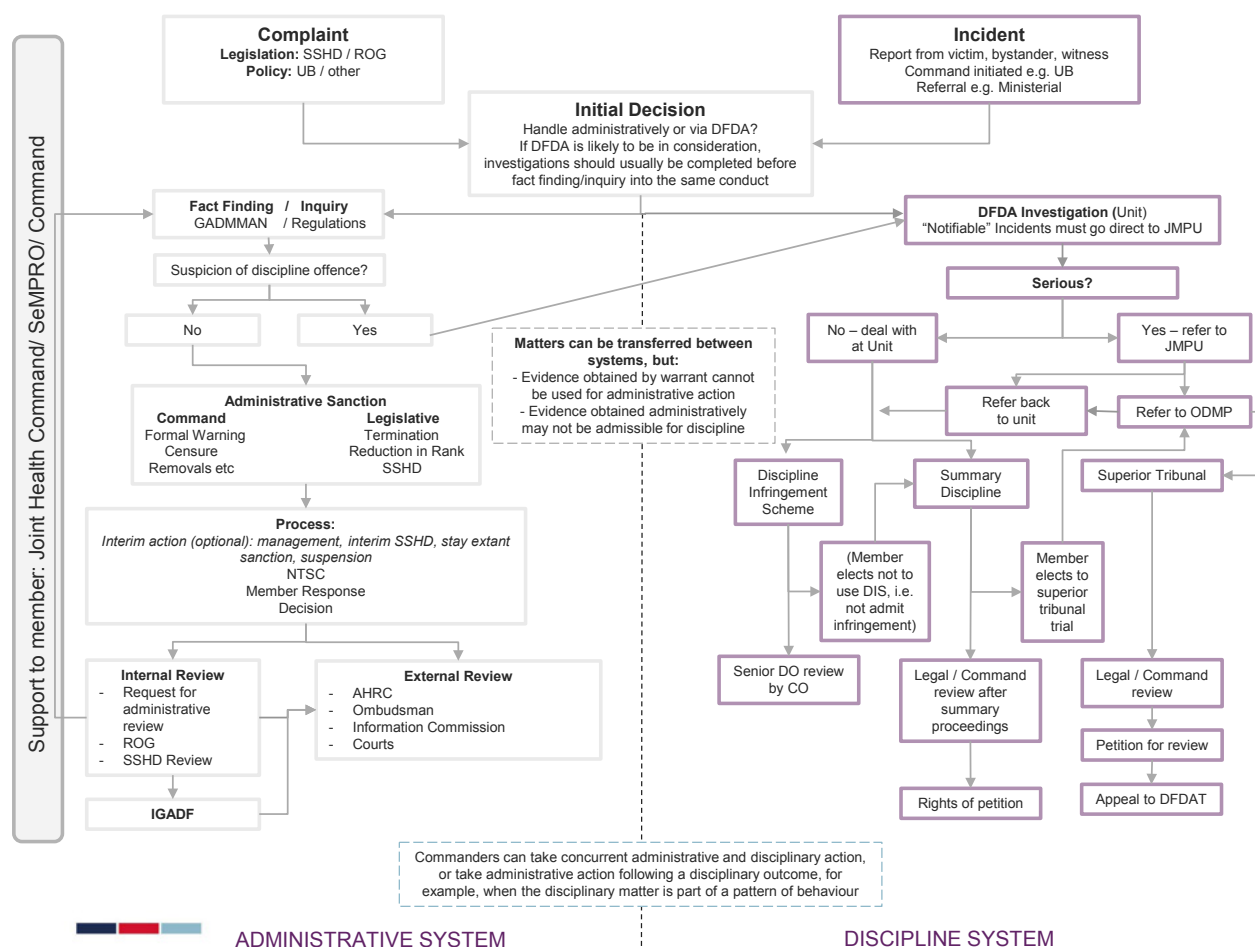
The administrative system

24. The administrative system is set out in the *Defence Regulations* under the *Defence Act*. Unlike the disciplinary system, it is not restricted to specific offences and can be used much more broadly. As set out in the Commanders' Guide to Discipline, the decision to use an administrative option is likely to be more intuitive and based on a commander's experience'.²⁹
25. The administrative system authorises commanders, supervisors and managers to take steps and impose sanctions to manage poor or sub-standard performance. Or to manage conduct that does not comply with Defence values, standards or policies (which may also include conduct that constitutes an offence under the Defence Force Discipline Act).³⁰
26. The various levels of administrative action and the members who are authorised to take those actions are set out in the *Defence Regulation 2016* (Cth) (and instruments of delegation made under it) and in the Military Personnel Policy Manual (MILPERSMAN).³¹ The Manual states:

a punishment is a penalty that is imposed by statute on a member for a breach of a disciplinary or criminal offence, whereas the imposition of an administrative sanction (eg formal counselling, warning or censure) has a whole of organisation protective purpose and is designed to reinforce the need for and to encourage members to maintain high standards of conduct and performance.³²

27. Even where an incident constitutes a service offence, a commander may nevertheless proceed with adverse administrative action if that is also available.³³ Administrative action against a Defence member may also be pursued where the conduct has resulted in a conviction for a service offence under the Defence Force Discipline Act or constitutes a civilian criminal offence.³⁴
28. Guidance for commanders on application of the administrative system can be found in documents including *Defence Regulation 2016* (Cth), the *Military Personnel Policy Manual*, and the *Good Decision-Making in Defence: A Guide for Decision-Makers and Those Who Brief Them*.³⁵ Defence witnesses in Hearing Block 11 also described two-day administrative law training in the pre-command course.³⁶
29. Administrative sanctions that may be imposed on a service member are wide in scope. They include suspension from duty; formal warnings and censures; corrective training; reduction in rank; formal or informal counselling; removal of security clearance; and termination of service where the Chief of the Defence Force determines that retention of the member's service is not in the interests of the Defence Force.³⁷
30. The latter is set out in Defence Regulation 2016 regulation 24(1). Not in the interests of the Defence Force means that members can be involuntarily separated for reasons not limited to criminal convictions or service offences but extending to performance, behaviours and suitability for service.³⁸
31. A member's conduct could trigger action under both the administrative and disciplinary systems.³⁹ Situations that could be managed under both include assaulting a subordinate, fraud, sexual offences, theft, drug and alcohol-related offences and a failure to comply with orders and instructions.⁴⁰ In such cases, command decides the most appropriate action to take.⁴¹
32. Figure 10.1 illustrates how structured decision-making might direct a complaint or incident through either the administrative or discipline system.

Figure 10.1 Illustrating the administrative and discipline system pathways



Source: Exhibit 86-03.052, Hearing Block 12, Military Justice System Overview, Annexure A, DEF.0000.0001.0033 at 0034.

33. While the military justice system is complex, Defence does provide training about military justice roles and how officers might undertake these roles, and even refresher training.⁴² However, Defence has not made it easy to navigate the system. Commanding officers and members are faced with more than twenty different regulations, policies, rules, guidelines, manuals and directions regarding the system and its application.⁴³
34. This was noted in the 2023 Commonwealth Ombudsman's report *Defending Fairness: Does Defence handle unacceptable behaviour complaints effectively?*:

Defence's complaint policies are complex, difficult to navigate and not always accessible to staff ... While views varied, many command teams observed the complexity and difficulty in navigating the various documents and determining what was required of them to handle complaints.⁴⁴
35. In addition to the complexity, Defence expects commanders to ensure the wellbeing of members engaged in the system and requires them to act in a trauma-informed way.⁴⁵

36. Reliable data and analysis, monitoring, assurance, accountability and governance are critical safeguards in a complex system. The need is increased because the system also relies heavily on the chain of command for its effectiveness and efficiency, as well as for ensuring the wellbeing of members. This chapter highlights deficiencies in these areas, and makes recommendations directed to strengthening oversight and support.

10.1.2 The military justice system, mental health, suicide and suicidality

37. Studies into civilian justice systems have shown that being subject to justice processes 'leads to both plaintiffs' and defendants' deteriorated mental health'. It shows 'the longer the exposure to the justice system ... the greater the deterioration of health'.⁴⁶
38. Defence's most senior commanders acknowledge the same is true for the military justice system.
39. Then Vice Chief of Defence Force and now Chief of Defence Force, Admiral David Johnston AC RAN, acknowledged that exposure to the military justice system, by its very nature, presents a psychosocial risk to members that may cause psychological harm.⁴⁷ He said Defence is alive to the fact that this risk applies to any member exposed to the military justice system.⁴⁸
40. Then Chief of Defence Force, General Angus Campbell AO DSC, also accepted there are multiple parts of the military justice system that may negatively impact a member's health and wellbeing, as well as 'unique aspects that might be related to military service in a justice system'.⁴⁹
41. Both Admiral Johnston and General Campbell acknowledged there should therefore be measures within the military justice system to ensure that those risks are aptly managed.⁵⁰
42. Prior to this Royal Commission, there had been limited consideration of the link between suicide/suicidality and the ADF's military justice system.
43. For example, the Australian Commission on Safety and Quality in Healthcare had recognised the link between contact with ADF police and the civilian criminal justice system and suicide. Its November 2021 report *Independent Review of Past Australian Defence Force and Veteran Suicides: Qualitative analysis of coronial and Defence documents* observed that:

Contact with ADF police and the civilian criminal justice system was a significant cause of distress for serving and ex serving members ... In cases where arrests and charges were made, individuals' mental health often declined, perceivably due to shame and fear, and in some cases precipitated their suicide.⁵¹

44. The report suggested that for ADF members, perceptions about damage to their reputation is a key stressor:

In almost all instances of criminal charges, serving members were concerned with consequences of the ADF being made aware of their charges. Some members went to great lengths to conceal their charges. Feelings of guilt, shame, fear of damaged reputation and failure were contributors to a person's suicide following criminal charges, arrest or other legal system contact. Many cases' deaths occurred prior to appearing at an upcoming court date, indicating that looming court proceedings could be a significant catalyst. Stress, feelings of hopelessness and severe shame were associated with depression, overdose, suicide attempt and suicide amongst those who had contact with the criminal justice system.⁵²

45. The report focused primarily on the link between civilian criminal charges and the suicide of an ADF member. To understand the potential link between suicide/suicidality and the ADF's military justice system, we undertook further analysis. Details are contained in Appendix I, Comparative rates of suicide – ex-serving ADF members, and Appendix K, Comparative suicide rates and select causes of death.
46. Our analysis found that men who had served in the permanent forces and who were convicted of an offence under the Defence Force Discipline Act by a summary authority (Commanding Officer or Subordinate) are associated with higher risk of suicide when compared to the general male population. Convictions under the Act's section 24 (absence without leave), section 29 (failing to comply with a general order) or section 60 (prejudicial conduct) are associated with higher rates of suicide. For more details, see section 10.5.⁵³
47. For men currently serving in the permanent forces, higher rates of suicide are associated with those who faced trial before a subordinate summary authority during service and convicted of an offence under section 26 (insubordinate conduct) compared to Australian employed males.⁵⁴
48. The results for women currently serving in the permanent forces and convicted of an offence are not reported due to small numbers limiting the conclusions which can be drawn.
49. We commissioned an analysis of Australian Institute of Health and Welfare suicide data, and also conducted our own analysis. This research found that being subject to involuntary separation as 'retention-not-in-service-interest' is associated with higher rates of suicide for ex-serving men and women.
50. The research shows:
- Ex-serving males who served in the permanent forces and separated involuntarily for the reason 'retention-not-in-service-interest' are around three times more likely to die by suicide than Australian men overall (197%).⁵⁵

- Women who served in the permanent forces and separated involuntarily for the reason 'retention-not-in-service-interest' are almost three-and-a-half times (245%) more likely to die by suicide than Australian women.⁵⁶
 - Ex-serving male-patients who served in the permanent forces and separated involuntarily for reasons other than medical, were 200% (or three times) more likely to be admitted to a public hospital for self-harm, compared to Australian male patients.⁵⁷
 - Ex-serving males who served in the permanent forces and separated involuntarily for the reason 'retention-not-in-service-interest' are 80% more likely to die in road crashes whereby the deceased was not a passenger (includes accidental, intentional, or undetermined intent) than Australian males.⁵⁸
51. The lower number of women represented in the data relative to men generally limited the statistical patterns we were able to identify for women. However, we note that submissions, oral testimony and private sessions indicate that for some women, engagement with the military justice system can at times be traumatic.
52. These findings highlight the increased risk for suicide for members who are either:
- an accused (whether or not ultimately found guilty of that offence) in a disciplinary process conducted under the ADF disciplinary system, or
 - whose service was terminated via the ADF's administrative system under *Defence Regulation 2016* regulation 24(1)(c) because 'retention of the member's service is not in the interests of the Defence Force'.
53. General Campbell acknowledged the risks for those involuntarily terminated under regulation 24(1)(c).⁵⁹
54. In response to our procedural fairness processes, Defence acknowledged that 'holding ADF members to account for misconduct, including through a military justice process, may have an adverse impact on that member's wellbeing.'⁶⁰
55. While the ability to hold members to account is necessary, in this chapter we consider the effectiveness of safeguards and supports, and if there is adequate oversight of processes and powers within the military justice system.

10.1.3 Management of mental health issues and the military justice system

56. A key difficulty for the ADF is that members with underlying mental health issues may more readily attract the intervention of the (inherently stressful) military justice system.
57. The underlying issues compound the member's distress, triggering a downward mental health spiral. The more the member's mental health declines, the more likely they are to engage in conduct (such as that associated with poor performance or alcohol abuse) that may attract further action under the military justice system. Commanding officers are not always well placed, or necessarily equipped, to identify and manage these issues.
58. In Defence's 2022 Wellness Action Through Checking Health project, 'change from usual behaviour' was one of the early indicators of changes in mental health identified by family members, leadership, and health service professionals.⁶¹
59. Other early indicators included sleep issues, absenteeism, reduced work performance, disengagement, anger issues, increased alcohol consumption and difficulty with everyday tasks.⁶² Any of these could lead to interaction with the military justice system due to the probability of these behaviours attracting administrative sanctions.
60. One lived experience witness, Ms Glenda Weston, described how deteriorating mental health can lead to poor behaviour and the attention of the military justice system:

when they become disruptive and aggressive and go AWOL [Absent Without Leave], they don't turn up for work and they [ADF] have to go looking for them, they must realise there is something bad happening, and it's not ... they don't take notice of it. They press charges or make it harder for them or they get admonished.⁶³
61. An ex-serving member described the flow-on effect after mental health issues led to being unable to perform optimally at work and then being disciplined for changes in behaviour, which resulted in their worsening mental health and attempted suicide.⁶⁴
62. We are concerned for members who are experiencing mental health issues who must then, while in poor health, attempt to advocate for themselves and navigate complex systems and situations, which may include facing involuntary separation.
63. If interactions with the military justice system can indicate declining mental health, this is an opportunity to provide early intervention services, such as referral to a psychologist. That relies on command discretion and their ability to identify an underlying issue.⁶⁵ That challenge was acknowledged by Brigadier Kahlil Fegan DSC, the Commander of the 3rd Combat Brigade:

Commissioner, I think one of the challenges for us is that those men and women at that tactical level that are in positions of responsibility probably aren't as attuned or aware of those potential mental health issues as arguably we would like our people to be ... reality, I suspect, is that quite often we'll need subject matter expert advice to inform that decision.⁶⁶

64. When asked how commanding officers might recognise and take mental health into account when considering action against a member with repeated administrative offences, Lieutenant Colonel Peter Francis, Deputy Director SO1 Separations, said:

I guess that's the thing. The commanders are not well positioned ... because they may not recognise those causal factors. The medical professionals are the best organisation we've got to identify that.⁶⁷

65. He added:

... I think there is more we can do to understand what are the implications of our taking disciplinary actions to ensure that the taking of the disciplinary action achieves the intent that we are seeking to achieve and doesn't compound a problem that we should have reasonably been able to understand because that is excessive and not what we should be doing. How we enable that effect is what I'm unsure about, how we could best achieve.⁶⁸

66. He also acknowledged that members may be reluctant to disclose mental health issues to their commanding officer due to stigma around mental health.⁶⁹

67. Air Commodore Patrick Keane AM CSC, Director-General of the Military Legal Service, agreed it is preferable to deal with people struggling with mental health through the health system rather than the discipline system. But that requires commanders to be able to identify that underlying mental health factors are at play.⁷⁰

68. These issues have also been explored in other forums:

- The Inspector General of the Australian Defence Force (IGADF) in the 2021–22 annual report highlighted that:

Evidence in recent IGADF inquiries reveals that mental health conditions are often unknown or not sufficiently disclosed to Joint Health Command and the chain of command. Further contributing to the complexities is that ADF members who are struggling with their mental health in the period immediately before their death, may be reluctant to seek help from medical professionals and/or the chain of command. Reasons for the reluctance related to perceived stigma in doing so, and the perception that the disclosure will lead to an adverse effect to their career.⁷¹

- In 2023, the Military Justice Legal Forum, an advisory forum to support military justice system governance, acknowledged the challenge facing commanders who must balance wellbeing and discipline needs.⁷²

69. Our recommendations to focus on this early opportunity for intervention and support for those engaged in the military justice system are detailed in section 10.6.
70. The current Chief of Defence Force, Admiral Johnston, accepts that a poor performing justice system negatively impacts the welfare and morale of the ADF workforce.⁷³ The following section focuses on fixing failings with the oversight of the system in order to minimise the heightened risk of suicide and suicidality from members' engagement with it.

10.1.4 Improving oversight of the military justice system

71. Governance, accountability and assurance mechanisms within the military justice system provide the oversight that enables the ADF to identify systemic issues and risks factors that contribute to member suicide and suicidality.
72. In the absence of these mechanisms, unmonitored and unmanaged issues that are risk factors for suicide and suicidality are more likely to occur. These issues include, but are not limited to:
- transparency and procedural fairness failings due to inconsistent application of administrative sanctions, leading to unjust outcomes for members
 - misuse and abuse of administrative sanctions
 - high rates of unacceptable behaviour
 - under reporting or mismanagement of sexual misconduct offences
 - other unchecked risk factors for suicide, suicidality or self-harm, such as involuntary separation for the reason 'retention-not-in-service-interest'.
73. Issues of oversight failure relate to all levels of the military justice system. They affect when a potential incident is first identified through to terminating a member's service.
74. Defence lacks comprehensive data analysis to show what is happening across the system, which would enable it to identify risks as they emerge and monitor and address them before they become entrenched. This is particularly relevant given commanders have discretionary powers in many decision-making processes. We consider Defence's approach to collecting data relating to suicide and member wellbeing in Chapter 29, Use of data and research by Defence and DVA.
75. In this section we set out the key governance roles, and consider the different assurance functions that enable system oversight by ensuring required information gets to those who need to know it in a timely matter. We will highlight deficiencies in the proactive identification of risks and potential risks, including those that contribute to poor mental health outcomes and suicidality. Finally, we look at changes ADF is undertaking.

10.1.5 Key roles in military justice system governance

76. The ADF has roles with specific responsibilities for governance of the military justice system. They are set out in Table 10.1.

Table 10.1 Key governance roles in the ADF

Role	Description
Primary responsible officer	Pursuant to <i>Defence Act 1903</i> (Cth) section 9, the Chief of Defence Force commands the ADF and therefore is the primary responsible authority for military justice. ⁷⁴
Accountable Officer	<p>Defined in the Defence Instruction: Administrative Policy.⁷⁵ The role given responsibility for the overall governance of the military justice system. This includes developing, implementing, maintaining and reviewing policies and procedures within the military justice domain, and ensuring appropriate coverage and guidance.⁷⁶</p> <p>The Chief of Personnel took responsibility as Accountable Officer on 1 November 2023, following the 2023 Defence Strategic Review. Before that, the Vice Chief of Defence Force assumed this role from July 2018.</p>
Governance Committee	<p>Chaired by the Policy Owner, Military Justice Steering Group (MJSG), it is a command-led strategic level committee that provides assurance to the Accountable Officer and Chief of Defence Force that the military justice system is working effectively.⁷⁷</p> <p>It meets quarterly and includes senior ADF legal officers and the chiefs of staff from the service headquarters together with invited members.⁷⁸</p> <p>It places items that impact the effectiveness and efficiency of the military justice system on the MJSG Forward Workplan, or they are raised as agenda items.⁷⁹</p>
Advisory forum:	The Military Justice Legal Forum is comprised of Defence lawyers and independent statutory authorities and provides advice to the MJSG. ⁸⁰
Director Defence Counsel Services	The Director Defence Counsel Services is an independent position whose position and authority stems from the Defence Act in Part VIID. They are appointed by the Minister for Defence. They provide legal support to accused persons. The Director must provide a bi-annual report to the Associate Secretary of the Department of Defence. ⁸¹
Coordination and support	Australian Defence Force Headquarters performs a range of select strategic issues management, coordination and assurance functions for the military justice system as requested by the Chief and/or Vice Chief of Defence Force. It supports the Chief of Defence Force in reviewing, and the implementation plans associated with, Inspector General of ADF reports into deaths in service. ⁸²
Inspector General of the ADF	Provides oversight of the military justice system independent from the chain of command. For detail see Chapter 12, Role and functions of the Inspector-General of the ADF.

Defence Committees	
Role	Description
Tier 1 Committee	The Tier 1 Committee (Defence Committee) is the highest level of decision-making in Defence and addresses issues that impact the whole of Defence and established top level organisational goals. ⁸³
Tier 2 Committee	Tier 2 Committees (include Chiefs of Service Committee, Enterprise Business Committee, Investment Committee, Strategic Policy Committee) assess issues that impact multiple domains, including military acquisition and operational preparedness, enabling functions, strategic policy and intelligence matters. ⁸⁴
Tier 3 Committee	Tier 3 Committees (for example, the Military Justice Steering Group), assess issues that impact within a policy domain and provide guidance to groups and services to ensure departmental policy is aligned and performance is measured against a standardised set of priorities. Tier 3 Committees support the relationship between strategic objectives and the operation of enterprise committees. ⁸⁵

77. The Defence website notes that ‘the military justice system provides safeguards for ADF members, including an automatic review of convictions and punishments and the right to an internal and external appeal’.⁸⁶
78. The site lists the following agencies as options for external avenues for complaint:
- Australian Human Rights Commission
 - Defence Force Discipline Appeal Tribunal
 - Defence Force Ombudsman
 - Inspector-General of the ADF
 - Office of the Australian Information Commissioner.⁸⁷
79. These agencies are covered in more detail in Chapter 11, Governance and accountability in Defence, and Chapter 12, Role and functions of the Inspector-General of the ADF.
80. We will be looking closely at how effectively these governance structures have been operating in identifying and reducing factors that contribute to suicide and suicidality in the military justice system.

10.1.6 Assurance of the military justice system

81. Assurance mechanisms assess the extent to which organisational processes enable the right information to get to the right people, at the right time, in the right way so a system functions efficiently and effectively. This includes performance management and risk management functions.

82. A Defence-commissioned 2020 review into the Military Justice Assurance Framework concluded that ‘the Military Discipline System was not supported by formal risk management practices’. The review, conducted by Axiom Associates, classified the overall risk maturity of the ADF discipline system as low. It was most critical of those at the system level.⁸⁸
83. The report defined three lines of assurance in an organisation:
- The first occurs within the business operational areas with arrangements to inform how well objectives are being met and risks managed.⁸⁹ Admiral Johnston said these included unit level policies and processes, such as training, selection and review mechanisms.⁹⁰
 - The second is associated with the oversight of management activities at the system level. This includes compliance assessments or reviews carried out to determine that policy, risk or quality arrangements are being met. This assurance provides insight into how well activities are being carried out in line with set expectations, policy and/or regulatory considerations. It is distinct from and more objective than, first line assurance.⁹¹
 - The third relates to activities specifically designed to provide the Secretary of Defence and the Chief of the Defence Force with an independent and objective opinion on the governance, risk management and control framework.⁹² Admiral Johnston gave examples of this, including IGADF audits, Judge Advocate General annual reports, Director of Military Prosecutions reports, and redress of grievance via the IGADF.⁹³
84. The review found a lack of second line assurance oversight that targets the system level. It said ‘current Monitoring, Evaluation and Reporting on the military discipline system is not effectively informing accountable and responsible ADF members, to support decision making’.⁹⁴ It said:
- Key ongoing challenges for ADF Management include developing a holistic and objective view on military discipline risks, performance, and quality; in order to understand the root causes or contributing factors to important risk events, or issues.⁹⁵
85. The report recommended the Military Justice Steering Group (MJSG) should own the second line of assurance. The Vice Chief of Defence Force accepted the findings of the Axiom report and recommendations in 2020.⁹⁶
86. In early 2021, the MJSG agreed to adopt ownership of the second line of assurance. The Steering Group noted that ‘assurance’ should encompass both the military justice discipline and administrative systems, with a focus on continuously improving them, treating risks and managing issues.⁹⁷ The MJSG terms of reference were changed to a charter in 2022 to reflect the requirement it adopt a ‘program broad’ assurance role, focused on risk oversight.⁹⁸

87. In line with the Axiom review, we are mostly interested in the establishment of the second line of assurance. Aspects of the third line relating to IGADF unit audits are discussed in the Chapter 12, Role and functions of the Inspector-General of the ADF. This process is generally working well, although we believe Defence or the IGADF should routinely track and monitor the outcome of audits to understand longitudinal themes. This would help the second line of assurance.
88. Relying on audits is a reactive mechanism for assurance and is not an effective strategy to identify and prevent or minimise harm. This was highlighted in Hearing Block 12 by Lieutenant General Simon Stuart AO DSC, Chief of Army, where an IGADF audit revealed concerning features of culture in a particular unit.⁹⁹
89. The IGADF also undertakes inquiries and investigations into alleged failures of the military justice system. This applies to both systemic and individual failures within the ADF.¹⁰⁰ IGADF functions are detailed in Chapter 12, however these inquiries also offer useful information about potential indicators of system risks and trends over time. The chapter also notes that Defence has not maximised the value of this information to inform assurance functions.

10.1.7 Establishing a system view – Level 2 assurance

90. System assurance allows governance committees to identify areas of concern and trends that can be drilled down to unit, and even individual level, should trends warrant further examination. This might include looking into units that have high risk factors around suicide and suicidality amongst members – for example, high rates of involuntary separation for the reason ‘retention-not-in-service-interest’, unacceptable behaviour complaints or high rates of administrative sanctions.
91. The 2020 Axiom report identified limitations in data as a significant issue undermining system assurance.¹⁰¹
92. During Hearing Block 12, then Vice Admiral Johnston gave evidence that this was an area in which further work is required. He acknowledged Level 2 assurance is necessary for the management of major strategic risks.¹⁰² He said not as much progress had occurred as he had hoped during his tenure as accountable officer.¹⁰³
93. General Campbell, then Chief of Defence, acknowledged that:
- we are currently weak at the second level of organisational assurance, not just in regard to the military justice system but across a range of functions in our organisation. It is, again, a heritage, not one to be put up with but a heritage of a federated system.¹⁰⁴
94. Vice Admiral Johnston recognised that lived experience evidence before this Royal Commission has shed a light on systemic weaknesses in the military justice system that he was not been previously aware of. He said the absence of a system assurance function makes it difficult to identify underperformance and address those issues within the system.¹⁰⁵

Quality data and analysis is foundational to assurance

95. The Associate Secretary of Defence, Matt Yannopolous PSM, who is the chair of the Enterprise Business Committee and ultimately responsible for the programs within Defence's Data Division, told us it is essential that senior leadership can draw on data.¹⁰⁶ He noted that 'having access to timely data is a serious and significant challenge for Defence'.¹⁰⁷
96. The 2021 IGADF Own-initiative inquiry stated that 'the interrogation of well-integrated data analysis on a regular and strategic basis would provide Defence's policy makers with insights for further policy improvement'.¹⁰⁸ We consider Defence's approach to data integration and analysis in Chapter 29, Use of data and research by Defence and DVA.
97. Ms Alexandra Shehadie, former Director of the ADF Cultural Reform Program, shared her concerns about data when conducting reviews into the treatment of women in Australian Defence Force Academy and the ADF:

I guess my main concern was Defence didn't know if or where predators were in the organisation, because the data just wasn't there and it was inconsistent. There wasn't ... we didn't know whether certain bases were problematic, those sorts of things, what was going on, why weren't people reporting, what [was] the [incidence] of this, what was the prevalence. So there were massive gaps and we were very concerned.¹⁰⁹
98. In 2020, the Australian Government approved funding for the CASE records management system. It is a 'simplified, integrated and standardised case management system for entering, tracking, resolving and reporting integrity and personnel related cases, including complaints'.¹¹⁰ As we note in the Chapter 29, CASE is Defence's replacement for the Defence Policing and Security Management System (DPSMS), Army Incident Management System (AIMS), Conduct Reporting and Tracking System (CRTS) and Complaint Management, Tracking and Reporting System (ComTrack).
99. CASE aims to amalgamate many disparate systems into one enterprise capability and support data capture and analysis to address the deficiencies in military justice system assurance.¹¹¹ In Hearing Block 12, Vice Admiral Johnston explained that CASE will provide an aggregation of incidents that have occurred, their management and timeliness of responses and actions. This will be across the three services, for both discipline and administrative systems.¹¹²
100. We note that CASE in and of itself will not necessarily improve the quality of data. Rather, CASE simply integrates existing data. As such, it will not fix poor record-keeping practices nor will it eliminate issues of duplicated records (see Chapter 29).
101. As of the time of this report, CASE had not been delivered to Defence. The original deadline was 2020 but during Hearing Block 12 the Associate Secretary advised us, with caution, that it was on track to go live in May 2024.¹¹³

102. We are concerned that the slow pace of change will continue to impact members. It must be prioritised and driven with urgency.

Barriers to ensuring quality data

103. Consistent and robust record keeping, data entry practices and data quality management are a foundational element to any assurance system. Effective trend identification, monitoring and risk management in the military justice system depend on the quality and accuracy the information entered into the system. Quality analysis is not possible if there are issues with data input.
104. Chapter 11, Governance and accountability in Defence, highlights the issues with data entry and record keeping, including within the military justice system. The chapter highlights the administrative burden on busy managers to meet governance and compliance requirements, highlighting siloed and repetitive processes and forms.
105. The chapter also recommends process improvement methodologies to streamline administration and reduce the burden on busy managers in order to increase the quality of data and compliance.

CASE is an incomplete solution for system assurance

106. The Military Justice System Assurance working group was established in May 2021 to support a vision of:

A mature MJSA system that captures and presents military justice system data that is comprehensive, at a whole-of-ADF level, high quality, authoritative and targeted. The format and presentation of the information must facilitate interpretation and analysis by MJSG members to enable timely decision making and identify opportunities for 'deep dives' into specific areas of concern.¹¹⁴

107. It was also tasked with determining what data points would be useful in identifying trends to inform the development of the CASE records management system.¹¹⁵
108. The Military Justice System Assurance working group completed this work in 2022. However, minutes from the November 2022 Military Justice Legal Forum highlight that the CASE system is still some way from delivery and will only deliver part of the assurance required.¹¹⁶
109. A paper to the MJSG in late 2022 confirmed only about 30% of the data required for assurance would be captured by CASE, and that CASE was 'not sufficient for a complete assurance solution'.¹¹⁷
110. Other activities such as the development of a Responsibility Assignment (RACI) matrix, establishment of a governance framework and analysing IGADF audits would also be necessary to meet assurance.

111. As well as the CASE rollout delay, it is disappointing that Defence has made limited progress in addressing these other activities required to meet the Level 2 assurance system, given this gap is not dependent on a complex IT program.¹¹⁸
112. We note in Hearing Block 12 Lieutenant General Natasha Fox AO CSC said establishing Level 2 assurance was one of the key challenges in her new role as Accountable Officer for Military Justice.¹¹⁹

Limited efforts to close the gaps while CASE is developed

113. With the long lead time and delays for launching CASE, Defence should have looked at analysing existing information sources.
114. The handover briefing from the Vice Chief of Defence Force to the Chief of Personnel in November 2023 highlighted other data sources that should be used alongside CASE to improve Defence's understanding of the effective functioning of the military justice system. They include Defence internal survey data, Australian Human Rights Commission administrative data, and Australian Bureau of Statistics and the NSW Bureau of Crime Statistics and Research SCAR survey data.¹²⁰
115. During the course of our inquiry, we have analysed Defence military justice and incident reporting datasets to obtain insights about risk factors within the military justice system that may contribute to suicide or suicidality amongst serving and ex-serving members. Defence could have also been using these datasets to conduct its own analyses and improve risk identification and management. However, it has not done so.
116. The 2023 Defence Workforce Experience Survey summary report includes trends on the prevalence of unacceptable behaviour, including bullying, discrimination, abuse of power, violent behaviour and sexual harassment; measures on the complaint process for unacceptable behaviour (such as timeliness, being kept informed, and knowledge of person taking complaint); and perceptions of the fairness of the outcome.¹²¹
117. Yet at no point has this information been used to assist MJSG in understanding and inquiring into the health of the military justice system.
118. The data referred to above, along with IGADF reports, have long been in place. However, Defence has made limited effort to use them to provide some visibility of the efficiency and effectiveness of the system.
119. Vice Admiral Johnston gave testimony that he allocated resources within ADF Headquarters to undertake some activities to analyse justice system performance.¹²² However this was just a one-off review of IGADF audits. What is needed is a sustained program of monitoring and analysis, drawing on information beyond IGADF audits to include Defence administration datasets and surveys so that trends, risks and issues can be routinely identified, monitored and managed.

120. Vice Admiral Johnston further testified:

[W]e can gain insights in the performance of units by looking at the number of incidents that occur, at the number of people who are seeking to leave that unit or transfer to different roles and responsibilities, the justice audits, as you describe. So there are workplace health indicators that do provide an insight into the general management and leadership that's occurring within a unit.¹²³

121. Yet Defence has not been undertaking any analysis of these data points to inform risk assessment and prioritisation of resources through the MJSG. There is no evidence that this information has been used to monitor, manage and respond to issues and risk in the military justice system.

122. The 2023 Commonwealth Ombudsman's Report *Defending Fairness: Does Defence handle unacceptable behaviour complaints effectively?* highlighted shortcomings with relying on Level 1 and 3 assurance functions to ensure a system operates robustly:

We were also advised that there are external inquiry and review processes, such as that provided by our Office and IGADF's audit function. While complaint handling frameworks including such review mechanisms is important, the onus to ensure compliance should not be on complainants and external bodies. Defence should have internal quality control and assurance mechanisms in place.¹²⁴

123. Vice Admiral Johnston acknowledged that Level 2 assurance is necessary for the management of major strategic risks.¹²⁵ Yet despite acknowledging this criticality, there has been no progress on establishing the other elements of assurance not dependent on CASE.

124. Defence has been unable to provide a reasonable explanation as to why a partial assurance system could not be established in this time. This is despite Vice Admiral Johnston identifying that data sources exist, which we identified in this section, that could provide some insight into the health of the military justice system.

10.1.8 Weaknesses in governance of the military justice system

125. There is a human cost to the current invisibility of the effectiveness and efficiency of the military justice system. It is currently not possible for Defence to assess compliance to policy, or to know if a particular unit or commander is displaying high rates of administrative intervention. Visibility of trends is essential to trigger curiosity, inquiry and accountability. Governance, accountability and assurance are critical safeguards against many of the issues raised in this chapter.

126. The 2022 Military Justice System update briefing to the Chiefs of Service Committee noted that:

Although there are defined and appropriate governance and assurance activities occurring, the military justice system currently lacks the broader system governance structure required to integrate these disparate activities and form a coherent system picture. This is needed to effectively manage and assure the system, enable timely responses to scrutiny, and drive confidence in the system.¹²⁶

127. This remains an issue, with a 2023 paper to the MJSG acknowledging that ‘an overall system governance structure ... is absent and necessary’.¹²⁷

128. It identified ongoing governance issues including:

- no formalised risk management framework to inform decisions about prioritisation of resources and escalation of risks and issues
- issues not being escalated to the appropriate forums for consideration and assistance in resolving
- where briefings have drawn attention to issues, there appears to be little action to address them.

Poor risk management in the military justice system

129. Risk frameworks formalise how risks are identified and managed, which provides transparency and accountability for how an organisation prioritises resourcing and efforts. Risk frameworks support a systemic and proactive approach where risks are identified and reduced or mitigated before they eventuate as issues.

130. The military justice system has no risk framework, despite the June 2020 Axiom Associates report finding that:

the Military Discipline System was not supported by formal risk management practices. Respondents outlined ongoing challenges with improving the overall ‘system’ for military discipline, treating identified ‘risks’ and managing ‘issues (both complex and routine); particularly if they were not time-based’.¹²⁸

131. The 2020 MJSG terms of reference stated the group is responsible for establishing and maintaining a risk framework for military justice.¹²⁹

132. The updated 2022 MJSG charter noted one of MJSG’s key activities is the establishment of governance risk and control including establishing and maintaining a risk framework for military justice.¹³⁰

133. The intention to develop a risk framework appeared on the 2022 workplan, then again on the 2023 workplan, and has been carried forward to the 2024 workplan. There was an update to the Chiefs of Services Committee in October 2023:

Assurance is the first of four workstreams for the MJSG. During 2023, the MJSG work plan included a task to establish and implement a governance and assurance framework for the military justice system (task 1.1). The MJSG Charter also requires development of a Risk Framework, and a Performance, Monitoring and Evaluation Framework, against which assurance is to be conducted ... Progress on this task and thus system assurance generally has been limited during 2023.

However, to date the assurance function has not been clearly allocated or resourced within Defence. The lack of a responsible senior staff officer, or staff area, continues to pose the major risk for the military justice system.¹³¹

134. Vice Admiral Johnston acknowledged MJSG has failed to establish a risk framework.¹³² He explained that capacity has been an issue.¹³³
135. Yet Vice Admiral Johnston told us in Hearing Block 12 that various initiatives were not progressed due to capacity constraints and the need to balance resources based on risk.¹³⁴ He reiterated that risk was a reason why initiatives were not progressed:

Q. What are the other barriers to these known solutions not being implemented?

A. So the organisational capacity is a key one, counsel. The [other] element of it is our understanding of the risk level here compared to risk levels in other areas. So I can explain what I mean by that is the justice system, as we have described this morning, has those three levels of risk. The first and the third, the one at the operating level and the independence one, are generally strong. Yes, there have been vulnerabilities in the second level of assurance which we need to improve, but in looking at the relative risks in the fixes that are needed, this has been an area that we have sought to progress, has moved more slowly, but we have had an understanding of the risks involved, part of which we have sought to mitigate through some of the other work that has been done within ADFHQ [Australian Defence Force Headquarters], but we have had to treat that risk as we have had the capacity to do so.¹³⁵

136. We question on what evidence base these judgements were made in the absence of any risk framework to provide transparency and evidence.
137. The absence of a risk framework means that risk factors such as administrative termination, weaponisation, and problem units with high rates of unacceptable behaviour, are likely to continue unidentified or unaddressed unless the IGADF happens to audit the unit, or enough members complain so as to attract attention. This results in ongoing harm to individuals that could have been reduced or avoided if Defence were less reactive and more proactive in risk and issue management.

Escalating issues in a more timely manner for resolution

138. We have observed examples of significant issues not being escalated in a timely manner to relevant committees regarding challenges in progressing military justice initiatives.
139. A paper to the MJSG on 6 September 2022 highlighted there was a lack of a ‘home’ for military justice system assurance, creating issues in terms of system development, alignment, consistency of application and the ability for accountable officers to perform governance roles.¹³⁶
140. The 2022 Annual Report to the Chiefs of Services Committee advised that:
- progress on improving military justice system assurance has been slow because there is no single clear lead within Defence with overall responsibility and resources for this function
 - work was focused on options to allocate military justice as a core business function to an appropriate area of Defence
 - the lack of a Military Justice Governance Policy was a barrier to progress on establishing a comprehensive assurance framework and was added to the 2023 Work Plan.¹³⁷
141. None of these updates sought intervention by the Chiefs of Services Committee.
142. In October 2023, three years after the 2020 Axiom report, the new accountable officer for the military justice system highlighted the significant risk these delays posed to the military justice system:
- The primary risk for military justice is that responsibility for system assurance is not clearly allocated or resourced in Defence. ADFHQ [Australian Defence Force Headquarters] currently conducts limited, narrowly defined assurance functions within existing resources. Introducing the Case Management System (CASE), expected in May 2024, will provide a larger data source but not assurance in the absence of a responsible area for detailed analysis. The MJSG does not have authority to allocate functions or resources, despite its active assurance work item. Thus, the MJSG is unable to assure the Accountable Officer that the system is operating effectively and efficiently as required by its Charter.¹³⁸
143. Vice Admiral Johnston gave testimony that he did not escalate to a Tier 1 committee the issues and risks created by slow progress to establish assurance due to resourcing constraints:
- I agree it has taken longer than it should, but that is, in part, formed by a view of the relative risk, given that other mechanisms available, as we’ve discussed today, at the level 1 and level 3, about the overall risks in the justice system.¹³⁹

144. Yet there was no risk framework, or consistent and regular analysis of themes from Level 1 and 3 assurance to inform actions and priorities.
145. The Vice Chief of the Defence Force accountable officer handover briefing to the Chief of Personnel noted the MJSG lacks authority to give direction or to make decisions regarding resources. It relies upon other central committees for direction and authoritative decision-making.¹⁴⁰
146. The briefing highlighted that measures that require a service or group to take the lead and apply resourcing often do not find a home. It gave an example of MJSG being unable to identify through discussion or consensus an owner for an ADF inquiry capability manager. It also noted similar challenges in progressing the second line of assurance.¹⁴¹
147. There was a two-year delay for the capability manager to standardise training, experience, mentoring and currency requirements for administrative inquiries. Vice Admiral Johnston explained that delay was due to resourcing and prioritisation, despite the Defence Committee, which is Tier 1, having directed it be established.¹⁴²
148. In Hearing Block 10, the Royal Commission heard evidence from Major General Stothart, the policy lead for this work, that he was not aware the Defence Committee had referred that initiative.¹⁴³
149. Vice Admiral Johnston conceded there was a breakdown in governance where a Tier 1 Committee (the Defence Committee) has directed work, a Tier 3 (MJSG) committee identified lack of resources as obstacles and yet this was never escalated back to the Defence Committee.¹⁴⁴
150. In Hearing Block 12, Counsel Assisting the Royal Commission told Vice Admiral Johnston that the Director of Directorate of Inquiries and Investigations within the IGADF had identified concerns to us in Hearing Block 11 about gross errors in departmental inquiries that should have been picked up by legal officers when they reviewed the inquiry reports.
151. Vice Admiral Johnston had been unaware of this, and acknowledged these were significant concerns that should have been brought to his attention. That was a breakdown in governance.¹⁴⁵
152. In acknowledging this, Vice Admiral Johnston said:
- Counsel, as we've indicated today, there have been circumstances where that's the case. I do have confidence in the people that inform – that are involved and the judgments that they arrive at. Equally, I would say I am the accountable officer and any failings in that system are mine to own.¹⁴⁶

153. We commend Vice Admiral Johnston's integrity and ownership of accountability. This is not an easy acknowledgment to make in a public forum. We also agree that the then Vice Chief of Defence Force, as accountable officer, had a significant part to play in the deficiencies in the governance structure. However, the issues need to be considered from a broader system perspective and these deficiencies are not the Vice Admiral's responsibility alone.
154. Frequent updates on the status of the military justice system and reforms made to the system are provided to the Chiefs of Services Committee through the MJSG. However, the narrow briefings and narrative-based structure of the meeting do not provide for a clear and transparent view of progress. As such, it is difficult for a busy senior executive to get a clear picture, in a transparent and easily accessible way, of the initiatives that are progressing and those that are not. At no point in the papers presented to the Chiefs of Services Committee is it evident that, for example, the risk framework was delayed by years. It was not clearly stated on other matters, such as the delays to assurance, or the workforce capability manager, that escalation of issues was required.¹⁴⁷
155. We reviewed all the minutes and papers of the MJSG and note the significant work and effort from those supporting this forum. There has been some great work with scarce resources, with some papers clearly presented, outlining assessment of the objective options to inform decision making. Corporate areas with a responsibility and expertise in governance should provide more assistance to the MJSG to ensure good governance, especially regarding the approach to risk management and status reporting.
156. Chapter 11, Governance and accountability in Defence, includes recommendations around mechanisms to improve reporting to committees. They include greater transparency and clarity about the progress in implementing initiatives, so the senior executives can focus attention on areas that are struggling and require intervention.

10.1.9 Current position

157. In Hearing Block 12, Vice Admiral Johnston discussed the recent transfer of the accountable officer for the military justice function to the Chief of Personnel. He said this stemmed from a need to better enable Defence to manage military people:
- from their enlistment through their separation and to harness all parts of the experience that a military person has through their career. Part of that, of course, is their interaction with the military justice system, in the same way that the Chief of Personnel is responsible for the health system that is provided to our people.¹⁴⁸
158. We welcome this more-coordinated approach to managing ADF members throughout their careers, including their health needs such as when they interact with the military justice system, especially with regards to their mental health during military justice action.

159. We have observed progress in governance of the military justice system:
- In a July 2023 brief to the Vice Chief of Defence Force, the Commander of the Directorate Select Strategic Issues Management noted that recent organisational realignment and staffing increases now enable the Directorate to provide support across four key areas – data, implementation, assurance, and lessons.¹⁴⁹
 - December 2023 MJSG minutes flagged the MJSG would provide a report back to the Chiefs of Services Committee with fully costed options on both the assurance function and the inquiry officer capability manager in the first quarter of 2024.¹⁵⁰
160. Chief of Personnel, Lieutenant General Natasha Fox, advised us in Hearing Block 12 that since assuming the accountable officer role she has established a process for formal review of minutes and feedback for each MJSG meeting.¹⁵¹
161. As part of our procedural fairness process, Defence advised that the Military Justice System Assurance Working Group was re-established under the MJSG in March 2024 to identify a risk and governance framework for the military justice system.¹⁵²
162. Its terms of reference require it to review, refine and finalise the Military Justice Risk Framework; this includes assessing and confirming strategic risks and risk owners; mapping and assessing existing risk controls at the first, second and third-line level; and proposing risk measures to assess the effectiveness of controls.¹⁵³
163. Defence also advised that the Military Justice Governance and Assurance function was allocated as a function to Military Personnel Division in April 2024 as a responsible staff area, and resource planning is underway.¹⁵⁴
164. Lieutenant General Fox noted she has lost two resources which were available to Vice Admiral Johnston when he was accountability officer: a summary discipline implementation team, and a two-star (Major General) position to give feedback and support in oversight of the MJSG.¹⁵⁵ We note the significant breadth of Lieutenant General Fox's role, and the weight of many of our recommendations are likely to reside within her jurisdiction. We hope that resourcing options ensure there is adequate support to succeed in this task.
165. This issue of assurance was first raised in 2022, as was the idea for a joint capability manager for administrative inquiries, and yet Defence is still scoping the solutions.¹⁵⁶ This is unacceptably slow. All the work identified by Defence has yet to move beyond scoping and towards meaningful change
166. While Defence advised of recent work underway to address some these deficiencies, most of this will not be developed before this Royal Commission comes to an end. We will not be in a position to ensure the momentum of this work, nor the effectiveness. Unfortunately, we have found that a number of promising discussions in the past have either not been followed through into implementation or action, or have been very slow to do so.

Recommendation 28: Coordinate governance, assurance and policy functions of the military justice system

Defence should establish a home for military justice governance, assurance and policy and provide sufficient resourcing to achieve the following functions:

- (a) monitor qualitative and quantitative data and analyse trends across the range of military justice processes and outcomes
- (b) prioritising strategies to improve military justice record-keeping and data input issues to remediate data quality and facilitate analysis
- (c) monitoring the effectiveness of implementation of recommendations from various military justice reviews (including Inspector-General of the Australian Defence Force), including activity and impact evaluation
- (d) continue to define military justice metrics and align them with health and wellbeing metrics, and in so doing, to:
 - (i) identify and monitor risks of misuse and abuse of military justice processes
 - (ii) track complaints and trends related to termination, offence type and investigation outcomes
 - (iii) identify members who are repeatedly subject to military justice processes
 - (iv) identify officers who apply disproportionately high numbers of administrative sanctions
- (e) establish and implement effectiveness measures for military justice reforms / key actions on the Military Justice Steering Group action plan
- (f) review current-status reporting on initiatives in line with good-practice governance principles.

10.2 Initial military justice processes

167. We now look at the different stages of the military justice system. As part of that, we examine the common thread unravelling throughout it: how each is affected when there is a lack of oversight, assurance and governance.
168. Before a member becomes involved in the formal military justice system, their commanding officer must decide whether they have been involved in an incident that triggers action within the military justice system. They must also determine whether that action should be within the discipline or administrative system, or both.¹⁵⁷

169. To help them make those decisions the commanding officer, or other decision-maker, has the choice of two avenues to obtain further information. The first is by using an informal 'fact find', while the second is a formal administrative inquiry.¹⁵⁸
170. The procedural fairness and transparency of both these processes, and the supports provided to members, are critically important in minimising wellbeing risks.

10.2.1 Fact finds

171. Chapter 3 of the *Good Administrative Decision-Making Manual* sets out Defence policy on fact finds.¹⁵⁹ It states the commanding officer will 'direct the factfinding officer on the method of fact finding', meaning the commander has discretion over how a fact find is conducted.¹⁶⁰
172. Evidence to our inquiry was that when they are poorly conducted, they can have significant, detrimental impacts on member wellbeing, as we show below.
173. A commander or other decision-maker can undertake a fact find themselves, or delegate it to a fact-finding officer.¹⁶¹ Defence's *Guidance for Commanders, Managers and Supervisors* says relevant considerations when selecting a fact-finding officer include background, experience and independence from the matter to mitigate the risk of actual or perceived bias.¹⁶²
174. The *Good Administrative Decision-Making Manual* says a unit-level fact find will not be appropriate in complex cases, for example where an incident is subject to mandatory reporting or there is significant uncertainty and a more formal investigation might be required.¹⁶³
175. The officer carrying out a fact find provides a decision brief to the decision maker who must then determine if there is 'sufficient relevant, reliable, credible and important evidence to establish the facts'.¹⁶⁴ The manual notes that:

In administrative decision-making, the decision-maker should be reasonably satisfied that a fact is more likely than not to be true. This is similar to the civil litigation standard of proof on the balance of probabilities.¹⁶⁵

176. The options then facing a commander include:
- no further action
 - administrative/management resolution
 - refer for discipline or criminal investigation
 - appoint an administrative inquiry
 - refer matter to external authorities
 - refer to a superior authority for consideration and/or action
 - refer for alternative dispute resolution.¹⁶⁶

Members' experiences with fact finds

177. Some fact finds have been poorly conducted and, in some circumstances, have had significant and detrimental impacts on Defence members' wellbeing.
178. Poorly conducted fact finds can lead to incorrect decisions about the need for administrative action. They can also have significant consequences for the members' lives, including involuntary separation for the reason 'retention-not-in-service-interest'. The degree of discretion and lack of transparency about fact finds, and the varying capability among fact find officers, also leads to inconsistencies in how investigations are undertaken. This undermines both the real and perceived fairness of the system.
179. A 2018 Defence report acknowledged that 'Fact Finders commonly highlight that Campus Courses do little to prepare them for investigations'.¹⁶⁷
180. Similarly, the Department of Defence's *Design Blueprint: Management of unacceptable behaviour complaints within Defence* noted that:

Responses of commanders and managers vary. The competence and risk appetite of the commander and manager, as well as the competence of a Fact Finder, contribute to how effectively a complaint is handled.¹⁶⁸

181. A witness in Hearing Block 5 noted the problems using 'generally untrained supervisors', stating:

An officer in the unit is usually given that task to gather the information where it is necessary to try and inform the CO [Commanding Officer] and it is written in a formal manner. But basically it can depend on the ability of that individual of how well that is done ... And although there is training given to individuals, it is not part of their day-to-day roles and responsibilities.¹⁶⁹

182. Our inquiry received multiple complaints about the broad discretion and perceived bias of command (or their delegates) in fact finding and the implementation of inquiry recommendations. The following submission described poor experiences with fact-finds leading to a loss of faith in the process:

In [redacted] I put in a complaint against the main perpetrator and this was found to be unsubstantiated due to poor fact finding and it later came out that the fact-finding officer had a personal relationship with the perpetrator and assisted him in this issue. Due to the failings in this process, there was an anonymous complaint put forward to IGADF on my behalf stating the fact finding was not done correctly. This complaint took greater than 12 months to resolve, and recently came back stating that there was no evidence of unacceptable behaviour or bullying that occurred.

Due to the failings of these fact findings, and the person walking away from what they did with no punishment (so far), I had to seek external mental health services while another victim of this man was medically discharged due to his degraded mental stability.¹⁷⁰

183. Another submission described perceptions of poor procedural fairness:

Even though there were no adverse findings found against me, it is the lack of procedural fairness that was applied to myself in lieu of affording someone with a relationship with senior leadership with preferential treatment.¹⁷¹

184. Mr John Armfield, an ex-serving member, gave evidence in Hearing Block 12 of limitations with the fact-finding processes, and the significant negative impact on his mental health.

185. Mr Armfield had complained about inadequacies in the response and support he received at Defence Force Recruiting Robina following the release of a report into the suicide of his brother who was also a member of the ADF. A fact find was then initiated. Mr Armfield later lodged a complaint to the Inspector General of the ADF regarding the fact find.¹⁷²

186. The IGADF found:

The fact finding into PO Armfield's complaint about matters at DFR was materially flawed. It could reasonably be open to an apprehension of bias because the fact-finding officer had had earlier dealings with PO Armfield's matter, it did not consider all relevant evidence and it went beyond its terms of reference to make conclusions about PO Armfield's mental health.¹⁷³

10.2.2 Administrative inquiries

187. An authorised officer may initiate a formal administrative inquiry under Part 3 of the *Defence (Inquiry) Regulations 2018* (Cth) (the Inquiry Regulations) for complex matters.¹⁷⁴ They often make that decision after a fact find has been conducted.¹⁷⁵

188. The *Administrative Inquiries Manual* sets out two types of formal inquiry:¹⁷⁶

- (1) An Inquiry Officer Inquiry can be initiated by the Chief of Defence Force or their delegate to inquire into any matter concerning Defence.¹⁷⁷ They are the most common form of inquiry and run for an average of 3-6 months. They are relatively easy to manage logistically.
- (2) A Commission of Inquiry (COI): appointed by the Chief of Defence Force, Minister for Defence or Secretary for the Department of Defence. A COI may also inquire into any matter within Defence, however, a COI is more formal and more complex than an Inquiry Officer Inquiry. COIs are often reserved for high profile, serious, complex or highly sensitive matters and will generally be initiated where matters affect a service or Defence as a whole.¹⁷⁸

189. The *Administrative Inquiries Manual* refers to the importance of the selection of Inquiry Officer Inquiries or Commission Officer Inquiry officers, since poor selection ‘can cause significant problems’ and may result in the inquiry being ruled invalid.¹⁷⁹ The manual advises that selection should include consideration of an officer’s ‘training, experience, skills, availability, and freedom from bias’.¹⁸⁰
190. Ultimately, consideration and implementation of recommendations arising from an administrative inquiry is at the discretion of command.¹⁸¹
191. Inquiries are subject to a legal review by a legal officer prior to being submitted to the Appointing Authority for endorsement.¹⁸² A legal review is a quality assurance and risk management step, and it is mandatory for Appointing Authorities to engage Defence Legal for this purpose.¹⁸³

Member’s experiences of administrative inquiries

192. Like fact finding, the conduct of administrative inquiries has attracted concerns regarding transparency and procedural fairness. During Hearing Block 12, then Vice Admiral Johnston (as Vice Chief of Defence Force) conceded that complainants might also be unduly traumatised by an inquiry that is poorly conducted.¹⁸⁴
193. While there is a four-day course for Inquiry Officers, it is not mandatory.¹⁸⁵ It was noted at the June 2022 meeting of the MJSG that training for Inquiry Officers was service dependent, and that there is no requirement for a refresher or currency check.¹⁸⁶
194. At the same MJSG meeting, it was further noted that approximately half of all Inquiry Officer Investigations lead to a submission being made to IGADF for review, and adverse issues with the inquiry were identified in approximately half of those submissions.¹⁸⁷
195. A legal review of twelve Inquiry Officer Inquiry reports between 1 July 2022 and 31 March 2023 found that nine (75%) of the Inquiry Officer Inquiry reports required rework. Six of these (50% of total) required significant amendments, and three required minor amendments, noting recurring legal issues in both the substance of the draft reports and the process adopted by the inquiry.¹⁸⁸
196. One review in particular identified a variety of legal issues, with notable limitations including the terms of reference risking being ‘perceived as showing subconscious bias or perhaps seeking to “influence” the IO [Inquiry Officer] towards a view that any unsubstantiated allegation may be ‘vexatious and/or contrary to Defence policy’.¹⁸⁹
197. Concerns about the impact of poorly conducted inquiries were also highlighted in a submission by Dr Kay Danes, a human rights advocate, Mr Glenn Kolomeitz, a director and lawyer at GAP Legal, and Mr Kerry Danes CSM, a veterans’ advisor, based on a qualitative analysis of the lived experiences of serving and ex-serving ADF members.¹⁹⁰

198. Their analysis recognised inherent conflicts of interest in the process where officers conducting inquiries are under the same chain of command where the incident or complaint was made.¹⁹¹ Other concerns were raised about the exclusion of evidence, witness collusion and a lack of governance.¹⁹²
199. Dr Danes and colleagues also note the problem with untrained Inquiry Officers who are selected because they have ‘appropriate management and/or research and analytical skills, communication and report writing skills’.¹⁹³
200. As highlighted in Chapter 12, Role and functions of the Inspector-General of the ADF, in a briefing by the then Director of the Directorate of Inquiries and Investigations, the following issues were identified that had not been picked up by departmental legal officers who were reviewing departmental inquiries:
- findings not supported by evidence
 - insufficient analysis of the credibility and reliability of witnesses
 - incorrect characterisation of complainants
 - manifest unfairness in outcomes
 - lack of procedural fairness
 - labelling of complainants, for example ‘vexatious litigant’, ‘sense of entitlement’
 - selective interview of witnesses.¹⁹⁴
201. We have also heard from members of their frustrations in not being kept informed through the progress of an inquiry or of the outcomes:
- After I made my complaint, I asked them when and how I would find out the progress of their investigation. They said that even though I was the one who had made the complaint, I wouldn’t find out the results of the investigation. Instead, the results of the investigation would be sent to my Commanding Officer, and it would be up to his discretion as to whether I would find out. This seems incredibly unprofessional as the person who is complaining about mistreatment since I should have the right to know what their findings are and be able to appeal their decision ... This process absolutely contributed to the helplessness I was feeling at the time, which made me feel as though nothing was going to happen about my mistreatment.¹⁹⁵
202. An MJSG member described their own experiences with the privacy aspects of the process as ‘both difficult and time consuming’, and the group agreed that it was problematic that complainants could not be properly notified of outcomes under the current ‘conservative’ approach to privacy.¹⁹⁶
203. Lieutenant General Fox, Chief of Personnel, gave evidence in Hearing Block 12 that while previously, conservative interpretations of privacy legislation restricted notification to members regarding outcomes, this has now been addressed.¹⁹⁷

204. While ADF policy through Defence's *Administrative Inquiries Manual* requires notification of outcomes to affected parties, evidence at hearings and submissions repeatedly suggest that this is not happening consistently in practice.¹⁹⁸
205. During Hearing Block 12, then Vice Admiral Johnston (as Vice Chief of Defence Force) gave evidence that he was not aware of the significant issues with the inquiry process until they were made known to him. There he told us this information would have caused him to have concern about how administrative inquiries are conducted in Defence.¹⁹⁹ This is illustrative of some of the major weaknesses of assurance in the military justice domain which we address in section 10.3.

Defence action to date

206. The Inspector General of the ADF, Mr James Gaynor, acknowledged in minutes from the MJSG in 2022:

There is a risk to complainants who could be unduly traumatised by an inquiry that is poorly conducted, which will not be resolved by a post-facto review, but [he] observed that there is rarely a perfect solution where humans are involved, and that checks and balances can be an appropriate solution in a resource-constrained environment.²⁰⁰

207. Defence has embarked on updates to policies and manuals to improve guidance on Administrative Inquiries, overseen by the MJSG:
- Updates to manuals, resources and courses: There has been a focus on updating information and resources for commanders and inquiry participants in the Administrative Inquiries Manual, on the Defence Intranet and in some training courses.²⁰¹ The Administrative Inquiries Manual was amended in October 2023 to include guidance on a trauma-informed approach to inquiries.²⁰²
 - Navy issued a new directive from June 2023, which indicates that people involved in an administrative inquiry should be given regular updates, at least once a month, as well as personal contact prior to notifications in writing.²⁰³ Navy will evaluate the usefulness of this by requiring commanders to collect feedback to be included in the Defence Incident Record when closing a matter.²⁰⁴ This was in response to our investigations.
 - Establishment of a centralised Administrative Inquiries Legal Review Community of Practice.²⁰⁵ Members of the practice are selected for specific training requirements and will be the only legal officers who can perform legal reviews of inquiries.²⁰⁶ Their review will be subject to quality assurance checks by a second legal officer.²⁰⁷ However, the MJSG acknowledged the recency of the initiative means this will take some time to take effect and noted that a lack of training has resulted in broader personnel resourcing issues.²⁰⁸
 - Joint Workforce Capability Employment Manager: At that June 2022 MJSG meeting, the MJSG resolved to establish an ADF Administrative Inquiries Joint Workforce Capability Employment Manager to standardise the training and

capability requirements across the services.²⁰⁹ The initiative to ‘manage the inquiry officer capability, including standardisation of training, experience, mentoring and currency requirements’ has been slow to progress.²¹⁰

208. We note in section 10.1.8 that despite Defence agreeing to appoint a Workforce Capability Employment Manager as early as June 2022, the Vice Chief of Defence Force’s October 2023 handover brief highlights that had still not happened. As we note earlier in section 10.1.9, the MJSG are to provide a report back to the Chiefs of Services Committee with fully costed options on the capability manager in the first quarter of 2024. This was due to the MJSG being unable to identify who should ‘own’ the role through discussion or consensus.²¹¹ We also note the governance failure in that, while the Defence Committee had made the referral to establish the position, it had not been notified about the delays.
209. The issues have been known by Defence for a period of over six years, and until this Royal Commission, there has been very little action to address the gaps in assurance, risk management and inherent defects in policies.

Recommendation 29: Establish a new role to improve training and communication on conducting inquiries

Defence should establish the Joint Workforce Capability Employment Manager as a priority, whose scope of work should include:

- (a) reviewing the effectiveness of training in how to conduct ‘fact finds’ and inquiries and ensuring that trauma-informed principles are embedded throughout the training
- (b) reviewing the effectiveness of policies and communication material related to ‘fact finds’ and inquiries.

Case study: Royal Commission in-depth inquiry

210. In 2022, the Royal Commission conducted an in-depth inquiry into the treatment of an ex-serving ADF member following a complaint of unacceptable behaviour. The public report of the inquiry is presented after Chapter 5, Military employment classification and medical separation, in Volume 2 of this report.
211. An in-depth inquiry is a closed hearing that draws together the evidence of the member, relevant Defence documents and statements from witnesses, ADF and Defence personnel. We used this form of hearing to obtain a comprehensive understanding of how a member might experience an incident end-to-end and to explore how Defence policies, procedures, sanctions and other governance mechanisms might impact a member. It did not attempt to substantiate the allegation but sought to understand the systemic factors in the management of the complaint that contributed to the risk of suicidality of the key witness.

212. The member's experience was complex and related to different matters that exacerbated the key witness's risk of suicidality, including their ultimate medical discharge.
213. Of relevance to this chapter is how Defence managed the member's complaint of unacceptable behaviour and the subsequent conduct of an Inquiry Officer Inquiry which resulted in adverse findings and outcomes for the key witness. We discuss our concerns about the disincentives from making complaints in more detail in Chapter 9, Unacceptable behaviour and complaints management.
214. We made four findings that Navy's management of the issues potentially exacerbated the key witness's risk of suicidality. These relate to:
- the conflicts of interest in clinical personnel and the chain of command discussing the member's mental health and wellbeing with the officer subject to the complaint
 - an inappropriate focus in the Inquiry Officer Inquiry report on the member's mental health that was based on speculation by people who were not experts
 - the appearance of partiality by withholding and redacting parts of the inquiry report and its attachments, and not adequately engaging with the key witness
 - the interruption of the key witness's recovery, due to the inappropriate conveyance of the termination notice, and unfair medical discharge against the treating doctor's recommendation.
215. The Military Justice Legal Forum discussed our in-depth inquiry during its first meeting in 2023.²¹² According to the minutes, it was acknowledged that '[c]urrently there is a lack of clarity and current guidance as to how commanders and supervisors should deal with mental health issues in the process of inquiries'.²¹³
216. In response to our inquiry, Defence undertook four initiatives of particular relevance to military justice. These include providing clear, practical guidance for commanders and inquiry officers on how to:
- address mental health issues and risks in the appointment, planning and conduct of administrative inquiries (*Administrative Inquiries Manual*)
 - objectively manage an Unacceptable Behaviour complaint and provide clear guidance on the relevance of the complainant's subjective perception and circumstances (*Complaints and Alternative Resolution Manual*)
 - communicate with complainants in a way that reflect trauma-informed best practice (*Administrative Inquiries Manual* and on the *Administrative Inquiries Resources Hub* (Defence intranet))
 - take a trauma-informed and person-centred approach to interacting with individuals, in line with Defence's 'Trauma-informed Principles'.²¹⁴ Then Vice Admiral Johnston told us Defence had launched the Administrative Inquiries Hub, an online portal with dynamic best-practice information in July 2023.²¹⁵ It includes resources on approaching inquiries in trauma-informed way, with a focus on engaging effectively with potentially vulnerable complainants.
217. We discuss trauma-informed practice and related recommendations in section 10.6 of this chapter.

10.3 Inconsistent application, misuse and abuse of the administrative system

218. Defence describes the administrative system as the management of general performance issues. Administrative sanctions 'serve to correct behaviour and/or protect the organisation and others from behaviours inconsistent with Defence values'.²¹⁶ The primary intent is to protect the good order and discipline of the ADF, rather than punish the member.²¹⁷
219. Defence has advised, and we acknowledge, that differing outcomes for individuals arising from military justice processes (including administrative action) may be necessary and just, taking into account individual circumstances which are rarely identical.²¹⁸
220. In referring to inconsistent application, we consider this to mean a reasonable consistency of process, as stated by the then Vice Chief of Defence Force in his evidence when he referred to 'the need for a more common approach to the methodology or the considerations that should apply'.²¹⁹ Underpinning this from members' perspectives are the principles of transparency and fairness.
221. The potential for misuse and/or abuse in the system is known to Defence. The Vice Chief of Defence Force's handover briefing to the incoming accountable officer for military justice noted that the 'greatest challenges to the administrative sanction system is the inconsistent application of sanctions across the ADF'.²²⁰ In testimony, the then Vice Chief of the Defence Force noted that inconsistent application of administrative sanctions, 'either in perception or reality, creates a lack of confidence ... amongst the workforce for the application of that system'.²²¹
222. MJSG minutes from 2023 acknowledged concerns about inconsistent application and the impacts on members:

Inconsistent application of administrative and disciplinary outcomes for ADF members has a direct impact on Defence capability. It can have negative impacts on the mental health of individuals and their motivation for continued service. More broadly, it can erode trust and support for the Defence organisation.²²²

223. In Hearing Block 10, Dr Jacqueline Drew gave evidence. She is a psychologist and Associate Professor at Griffith University with 20 years of experience in law enforcement as a practitioner and researcher. Dr Drew highlighted the detrimental psychological impacts of maladministration, stating:

Organisational injustice is pivotal in predicting psychological distress and burnout amongst our employee cohort ... It manifests itself in terms of feeling betrayed. So, particularly, when we think about first responders, police and Defence, they often have very clear sense of right and wrong and we ask them to implement that sense of right and wrong within our communities ... It's then a significant disconnect when they don't see that same application of justice, that same application of right and wrong and the reward for good behaviour within the very agency that they work.²²³

224. Professor Ben Wadham, Associate Professor James Connor, Dr Kellie Toole and Professor Emma Thomas in their 2023 report *Mapping Service and Transition to Self-harm and Suicide*, commissioned by us, also highlighted that:

the more that the veteran interviews reflected on the importance of compassion, care, and nurturance within the military, the greater was also the use of stress language within that interview ... the more that veterans talked about grievances and a lack of fairness, the more that they also evidenced psychological stress and lower well-being.²²⁴

225. Indeed, Defence analysed 63 Military Justice Performance Audits from 1 January 2021 to 30 September 2022. Of these, five audits found the unit's military justice practices were materially deficient. Defence found in one Air Force unit, that junior ranks are more likely to experience poor morale due to 'high tempo, perceptions of lack of fairness and accountability, inequitable treatment and low confidence in command'.²²⁵

226. Then Vice Chief of Defence Force, Vice Admiral Johnston acknowledged in testimony that a poor performing justice system can negatively impact the welfare and morale of the workforce.²²⁶

227. In February 2023, Australian Defence Force Headquarters submitted a paper titled 'Consistency of application of administrative and disciplinary action in relation to members subject to civilian court and superior military tribunal processes' to the MJSG. It outlined Chief of Defence Force and Vice Chief of Defence Force concerns about the inconsistent application of administrative and disciplinary outcomes for ADF members:

As a general principle, the more egregious the alleged misconduct, the greater the imperative for Defence to be seen to be taking some form of action – interim or substantive – to ensure the protection of other individuals within the organisation and, in certain cases, the broader community from the member. However, Defence senior leadership have expressed concern as to whether administrative and disciplinary processes are being applied consistently and the impacts of misalignment with organisational, community and political expectations of Defence.²²⁷

228. Vice Admiral Johnston clarified in Hearing Block 12 that taking a more consistent approach should not lead to an 'expectation that there is a one-case outcome', because the decision maker must consider the particulars of every matter.²²⁸

229. The IGADF has noted a lack of visibility over administrative action as a point of concern:

Further, with the increasing trend towards the use of administrative action and away from the *Defence Force Discipline Act*, the consequent opacity is a cause for concern; the enterprise is unaware of how consistently and rigorously administrative action is applied and the deterrent effect is further undermined by the failure to publicly report even anonymised outcomes.²²⁹

230. Vice Admiral Johnston also recognised that within a significantly limited assurance system, 'it is weakest in the administrative sanctions outcome'.²³⁰

231. Defence advised as part of the procedural fairness process that these issues will be addressed by a Chief of Defence Force directive.²³¹ We again highlight, in the absence of assurance frameworks, Defence cannot guarantee the effectiveness of this strategy. We also highlight the findings in Chapter 11, Governance and accountability in Defence, of Defence's tendency to undertake a 'tick and flick' approach to entrenched issues.

232. We have heard through lived experience testimony and submissions that members do not perceive that the application of administrative action is used fairly in light of the far-reaching impacts on members' lives and wellbeing.²³²

10.3.1 Perceptions of misuse and abuse within the administrative system

233. Defence advised us in a submission on the military justice system:

The ADF's Ethics Doctrine specifically recognises that:

The ADF is a hierarchical system, where those with rank occupy positions of authority over subordinates. In hierarchical systems, the abuse of authority is an inherent risk. The ADF's values and approach to ethics represent a line of defence against the risks of unconstrained power through command. Assurance comes through accountability for commanders who fall short of professional standards, in their own decisions or in the military justice climate fostered in their unit.²³³

234. Despite this, Defence has not sufficiently prioritised establishing a framework to effectively monitor and manage the inherent risk of abuse as it does not have a system that allows early and proactive identification of indicators of misuse and abuse in the administrative system. We acknowledge work is underway, however as this is occurring at the same time as our Royal Commission, we cannot comment on the effectiveness.

235. Professor Ben Wadham and Associate Professor James Connor in their paper titled *Research into Defence Abuse 2018–2022* refer to this misuse of authority as ‘weaponisation’ of the administrative system, or ‘administrative violence’.²³⁴ The paper defines administrative violence as:

the discretion commanders can draw upon within a closed military justice system to harass and discriminate against a serving member. Administrative violence is how commanders use military justice to harass, disadvantage, violate, or socially terminate members deemed troublesome or anathema to unit or ADF success.²³⁵

236. And:

actions that are undertaken within institutional rules that are designed to further traumatise, belittle and/or restrict access to support and/or redress.²³⁶

237. Perceived misuse of the administrative system has been a theme in the 2011 *Report of the Review of allegations of sexual and other abuse in Defence: Facing the problems of the past*. It found that ‘an inconsistent (and in many cases, flawed) application of the military justice procedures’ was seen to contribute to disillusionment and under-reporting of abuse.²³⁷

238. Professor Wadham’s and Associate Professor Connor’s paper *Research into Defence Abuse 2018–2022* found a significant theme relating to the misuse of the administrative system and the subsequent impacts on mental health:

Administrative Violence (AV) was identified as a secondary trauma by many of our survivors ... AV typically followed the reporting of abusive incidents, where the survivor was then targeted, using administrative rules, to punish them for speaking out.

Survivors found it very difficult to challenge AV as they were already traumatised, lacked institutional knowledge to argue their case and were often left with no or ineffective representation and/or support.

The outcome of AV on the member was a complete break in trust of the ADF/DVA. This significantly impacted their ability to access or use support services.

The trauma produced by AV is best described in terms of moral injury including betrayal, marginalisation, and a loss of trust and hope.²³⁸

239. This outcome was based on an analysis of interviews and written statements from ex-members and stakeholders engaged in defence abuse matters, and publicly available material.²³⁹ We note, however, that none of the reported abuse that forms the focus of the study took place after 2018 and therefore efforts made by Defence to improve administrative system processes are not reflected.²⁴⁰

240. However, the 2023 research paper *Mapping service and transition to self-harm and suicide*, commissioned by us, collated 113 interviews from participants who served in the ADF from 1960 until 2022.²⁴¹ The research paper found that:

Military institutional abuse includes hazing and bastardisation, physical assault, sexual assault, extreme endurance training, reputational damage, sabotage, and administrative violence.²⁴²

241. Professor Wadham and others point to ‘approximately 35 inquiries since 1970 on and by the ADF on military culture, military justice, complaints handling, institutional abuse and women’s participation’.²⁴³ The prevalence and recurrence of these themes suggests that the ADF has not addressed the recommendations in these inquiries effectively.

242. Chapter 11, Governance and accountability in Defence, highlights numerous examples of Defence’s limitations in meaningfully addressing underlying problems highlighted through reviews and inquiries.

243. We too have received multiple submissions where a member or ex-member perceived the threat of administrative action underscored heavy-handed approaches to a minor infringement. The actions taken were felt to be demeaning, humiliating, or physically punishing. One member reported to us:

I was late to open the pool at 6am on Christmas morning. As a punishment, the senior PTI [Physical Training Instructor] took me on ‘a run’. He ran me until I vomited and nearly collapsed. I was told I was weak and pathetic.²⁴⁴

244. Another member stated:

One morning on the inspection parade, [the Commanding Officer] told me I had missed an area on my face and made me run back to my dormitory to shave again. After returning to the course, [the Commanding Officer], told me I lied and had not shaved again and made me run back to my dorm to shave again. I was made to repeat this seven times that morning, and only when I was bleeding from the face was [the Commanding Officer] happy, in fact, he mocked me because I was bleeding and said that is how I had to look every morning.²⁴⁵

245. In another submission we were told:

I forgot to salute [an admin officer] (I had my hat off as it was inside), he berated me for my indiscretion, made me salute him (and fair enough, I had stuffed up) then I stated my business. When I got back to my comcentre he had phoned my boss and demanded that I be punished for failing to salute him, this punishment was to stand at the front gate in 40 degree temperature on a Friday afternoon for 4 hours saluting every car that left. It was designed to humiliate and cause distress, I could only managed 3 hours before I got heat stroke. He demanded that I pay back that extra hour I had missed.²⁴⁶

Formal warnings

246. The *Military Personnel Policy Manual* defines formal warnings as a ‘written caution imposed on a member informing them that if their conduct, performance or standards do not improve further action may be taken against them’.²⁴⁷ While under a formal warning, members ‘should not expect to be promoted or selected for certain postings or training courses’.²⁴⁸ Accepting the policy recommendation that formal warnings are not to be used for minor incidents, formal warnings are recorded on the balance of probabilities.²⁴⁹ Many members’ submissions raised the impact formal warnings can have.²⁵⁰
247. Formal warnings typically last three to 12 months, but the manual says the duration is ‘discretionary’ and depends on the context of the case.²⁵¹ Formal warnings are recorded on a member’s PMKeys (the electronic personnel management system) and retained as a permanent record.²⁵² Even after a formal warning has expired, the record of the case ‘may still be considered in relation to a member’s competitiveness for promotion, postings and training courses’.²⁵³
248. Members made submissions describing their distress at the career impact of a formal warning and their sense of injustice about processes that led to this sanction, with one saying:

This had a massive impact on my career as that formal warning was later used as evidence to raise an “unsuitability for mustering” which resulted in moving to another mustering, and months away from home to do initial training as well as a significant reduction in rank and pay. I have long felt that the administrative process is too easily used as a weapon of bullying and coercion rather than its original intent.²⁵⁴

249. In Hearing Block 11, Reverend Dr Nikki Coleman, a chaplain in the RAAF, described how certain commanders use records of conversations (ROCs) to exert power over their subordinates. She said:

A. I think in theory ROCs can be used to assist members to understand where they’re having problems and to actually assist them to get better. However, my experience of ROCs as a chaplain and personally is that ... it compounds the trauma that you are working through. It is not a trauma-informed approach. It would be the opposite.

Q. Have you heard of cases where ADF members are being threatened with being ROC’d?

A. I, as a chaplain, would hear that on a daily basis and I personally experienced that. My abuser threatened to ROC me repeatedly.

Q. What did that tell you about this ROC process, about what it really is?

A. That it’s not used to assist members in how they can improve, but is actually used to threaten members. It’s been weaponised, effectively.²⁵⁵

250. In one submission, a member describes being singled out and constantly charged for minor infractions as a form of bullying, and when the member moved units to avoid this commander, the new Sergeant said to them, 'did you know they were having bets on who was gonna get to charge you next'.²⁵⁶

251. Another member reported the negative impact of threatening behaviour on their mental health:

My seniors in the ADF accused me of a crime I had not committed, and then ordered me to admit to it. I refused, and was chastised for being insubordinate. I was told that if I did not admit to things and beg forgiveness 'things would get much worse for [me]'. I was also told that the intent was to use the Administrative System because it had little burden of proof and was 'just designed to fuck [me]' ... Upon proving my innocence I received a formal warning and was sent home from the operation. The OC [officer in charge] changed my support person three times in this period and each time this occurred it occurred immediately after I provided a response to one of the numerous notices to show cause that was not to the OC's liking ... I was severely traumatised as a result of the events ... I have lost two jobs as a result of my ongoing mental health problems that the ADF caused.²⁵⁷

252. We have heard countless similar stories. The cumulative impact undoubtedly undermines the confidence of members who are aware of incidents like these occurring in their workplaces, and their trust in the ability of Defence to prioritise or safeguard the wellbeing of their people.

253. When questioned about this, then Vice Admiral Johnston testified that weaponisation of administrative sanctions may have occurred in individual cases, but he did not think this was a systemic issue.²⁵⁸ We have not seen any steps Defence has taken to assess if there has been weaponisation and if it is systemic. The only thing preventing Defence from doing this analysis appears to be its failure to capture and collate centralised data.

254. As highlighted in section 10.1.7, Defence witnesses acknowledged there 'is no system view' over the military justice system. In the absence of any monitoring and assurance framework, it is not possible for it to identify trends regarding misuse, abuse or weaponisation of the military justice system, a failing discussed in section 10.3.

255. The Inspector General of the ADF Mr Gaynor told us in Hearing Block 11 'there will be an own-initiative inquiry into the weaponisation of the military justice system' as he had become more aware members perceived it was happening.²⁵⁹ However, at the time of writing this report, there is no indication the inquiry has commenced.

10.3.2 Progress to date

256. In May 2023, the MJSG proposed a work program to improve the consistency of the application of the administrative system:

The Directive will encompass both interim actions at the start of a relevant process (eg investigation of an alleged offence) and final actions once an outcome has been reached (eg a conviction in civilian court or superior military tribunal). It will also make clear that, while initiation in specified circumstances may be mandatory, the imposition of a suspension, termination or security restriction will depend on the relevant decision-maker's unbiased assessment of all relevant facts to hand.²⁶⁰

257. The program aims to increase commander understanding of 'discretionary decisions' to improve consistency of application.²⁶¹ This includes knowledge of legal precedent and mandatory actions, and potential wellbeing risks to members involved.²⁶²
258. We note elsewhere in this final report (especially in Chapter 7, Culture and leadership) that Defence culture strongly influences behaviour. This impacts the levels of acceptance of institutional abuses and perceptions of how far power can be stretched without consequence.
259. Progress toward better integrated policy is a positive step. However, more significant efforts are needed to identify, monitor and address the risks highlighted.
260. We are keen to ensure that Defence prioritises and actions with urgency its proposed initiatives, and they do not follow the slow path of previous initiatives in this space.

Recommendation 30: Prioritise the Inspector-General's inquiry into the weaponisation of the administrative system

The Inspector-General of the Australian Defence Force should initiate an own-initiative inquiry into the weaponisation of the military justice administrative system by the end of 2024.

The inquiry should consider how to improve accountability of commanders who are found to misuse and abuse military justice processes. Measures to identify misuse and abuse may include monitoring trends in administrative sanctions and locations, cohorts, roles or ranks found to be associated with disproportionately high rates of sanctions.

10.4 Administrative termination

261. The *Defence Regulation 2016* (Cth) authorises statutory decision-making that has the most serious consequences for members, including separation from service (termination). A member's service may be terminated for reasons that include 'not in the interests of the ADF.' This is defined in a non-exhaustive list in Regulation 6(2), including behaviour, conduct, criminal convictions, the morale, discipline and welfare of the ADF or the ADF's reputation and community standing. Other reasons for termination of service include redundancy and failure to meet a condition of enlistment.²⁶³ We also consider administrative termination in Chapter 5, The military employment classification system and medical separation.
262. Involuntary separation is identified as a risk factor in suicide and suicidality statistics for ex-serving members who served in the permanent forces of the Australian Defence Force, with those members separating involuntarily having a higher rate of suicide compared to the Australian population.²⁶⁴
263. The suicide rate for ex-serving men who served in the permanent forces and who separated involuntarily for the reason 'retention-not-in-service-interest' is around three times the rate of Australian males (197% higher).²⁶⁵
264. Within that cohort, those aged under 40 years, or who served for less than ten years, or separated within five years, were identified as at-risk subpopulations.²⁶⁶
265. Those separated for the reason 'retention-not-in-service-interest' form a newly identified at-risk group. Of the sub-populations studied in this analysis for ex-serving males who served in the permanent forces, the 'retention-not-in-service-interest' separation cohort has the highest difference in the rate of suicide compared to the respective age-matched Australian male. This finding suggests any speculation that higher rates of suicide in the involuntary medical separation cohort are related solely to medical conditions is unlikely to be true.
266. The suicide rate for ex-serving women who served in the permanent forces and separated involuntarily for the reason 'retention-not-in-service-interest' is more than three times the rate of Australian females (245% higher).
267. The Australian Commission on Safety and Quality in Healthcare conducted an *Independent Review of Past Australian Defence Force and Veteran Suicides: Qualitative analysis of coronial and Defence documents*. It said:

Cases where ADF members took their lives seemingly pre-empting involuntary disciplinary or medical discharge demonstrated the extreme despair some members felt about being discharged. Distress over discharge was commonly related by inquiry officers to uncertainty about future meaningful employment prospects (civilian or ADF) and associated financial and social stability. Distress also related to a sense of failure that the member could not succeed in the workplace they esteemed and worked hard towards.²⁶⁷

268. In Hearing Block 11, Judge Douglas Humphreys OAM discussed the detrimental impact of involuntary separation for the reason ‘retention-not-in-service-interest’ on ex-serving members’ mental health during his time at the Veterans Review Board. He said:

When I was at the veterans Review Board, it was clear to me that people who were terminated from the Defence Force in circumstances where they were not happy suffered ... [were] far more likely to suffer a period of depression/ anxiety or other issues.²⁶⁸

269. This section explores the need for stronger safeguards to manage the risks to wellbeing for members who are subjected to an involuntary separation process.

10.4.1 Policy overview

270. Defence’s ability to terminate a member under the ‘retention-not-in-service-interest’ provisions is to be found in the distinction between ‘service’ and ‘employment’. As set out in a Defence submission:

The administrative arrangements for ADF members, including sanctions and personnel-related decisions, are based on the principle that ‘service’ is not ‘employment’ but is now a unique concept in Australian law. Section 27 of the Defence Act 1903 makes clear that there is no contract with the Commonwealth connected with the service of a member in the ADF. That provision has been part of the Defence Act since it was first passed.

The High Court has acknowledged that, historically, the members of the ADF served ‘at the pleasure of the Crown,’ or, as it is sometimes put, as ‘servants of the Crown.’ For this reason, the administrative ‘power to dismiss could be exercised at any time and for any reason, or for no reason or for a mistaken reason’ as a matter strictly of law.²⁶⁹

271. Defence noted the regulations have been amended over time to strengthen provisions and provide checks and balances to reflect the ‘legal standards expected in the community’.²⁷⁰

272. *Defence Regulation 2016* (Cth) subsection 6.2 outlines the considerations for determining if retention of a member’s service is not in the interests of the Defence Force:

- (a) a member’s performance
- (b) a member’s behaviour (including any convictions for criminal or service offences)
- (c) a member’s suitability to serve:
 - (a) in the Defence Force
 - (b) in a particular role or rank

- (d) a member's failure to meet one or more conditions of the member's enlistment, appointment or promotion
- (e) workforce planning in the Defence Force
- (f) the effectiveness and efficiency of the Defence Force
- (g) the morale, welfare and discipline of the Defence Force
- (h) the reputation and community standing of the Defence Force.²⁷¹

273. Decision-making for an administrative termination consists of:

- (a) an 'initiating authority', usually the commanding officer of the member involved, who makes a recommendation for termination²⁷²
- (b) an 'imposing authority', usually from the relevant career management agency (for example, the Career Management Agency in the Army), to whom the Chief of Defence Force delegates to make a termination decision based on the recommendation and information provided by the initiating authority, which includes written submissions from the member.²⁷³

274. When a commander issues a notice of proposed separation to an individual (a notice to show cause), they must include the action that is proposed, the reasons for the proposal, and invite the member to provide a written response as to why the proposed action should not be taken.²⁷⁴ The member has 14 days to provide a written response, which the commander may consider as evidence to justify the member's retention in service.²⁷⁵

275. If the commander is not satisfied by the member's response, if the member states in writing that they do not intend to provide a response, or if the member does not respond within 14 days, the proposed separation notice is passed to the imposing authority for their decision.²⁷⁶

276. The imposing authority may then decide to separate the member, impose a lesser administrative sanction, or take no further action.²⁷⁷

277. We recognise that Defence needs the ability to terminate the service of members to protect the service and other ADF members. We discuss some of the general challenges of separation in Chapter 23, Transition from military to civilian life.

278. However, members who are involuntarily terminated are at higher risk of suicide than those who voluntarily separate and it is therefore not a decision that should be taken lightly. When that decision does occur, it should be accompanied by reasonable safeguards, acknowledging the unique circumstances of a forced transition, to protect the health and wellbeing of the separating member.

The broad definition of ‘interests of the Defence Force’

279. We note that the grounds for administrative termination are broad and highly discretionary. Commanders may choose to recommend that a member is involuntarily separated due to their retention being ‘not in the interests of the Defence Force’.²⁷⁸
280. In Hearing Block 11, Judge Humphreys noted that the application of the section 24(1) (c) ‘not in the interests of the Defence Force’ provision is supported by its broad definition in section 6(2) of the *Defence Regulation 2016* (Cth). He said ‘[t]he grounds that are set out for the basis of termination are so wide they are virtually impossible to challenge’. He noted administrative termination can have ‘incredibly damaging impacts’ to member wellbeing.²⁷⁹

281. This has also been highlighted by other judicial officers. Justice John Logan said:

The very definition of the ‘interests of the Defence Force’ in the Defence Regulation makes it plain that discipline of the ADF can be a reason for the early termination of the service of a defence member. But the adoption of this method is attended with nothing like the ‘due process’ requirements of prosecution under the DFDA [Defence Force Discipline Act] in respect of a service offence.²⁸⁰

282. Professor Pauline Collins, from the School of Law and Justice at the University of Southern Queensland, also highlighted minimal protections in the current process:

The administrative sanction that can result in a termination is attended by no more than a notion of procedural fairness. It does not attract any rights to a hearing, normal evidence requirements, where or how the evidence of the alleged conduct arose, or ability to question any witnesses or informants. The broad basis for administrative termination in s 24 of the Defence Regulations 2016 enables the widest grounds for discretion in terminating a defence member ... administrative termination has minimal protections and certainly less than in the DFDA [Defence Force Discipline Act] for service offences. Somewhat surprisingly Defence believes it is appropriate to terminate a member’s service administratively despite that same member being acquitted of a service offence based on the same facts.²⁸¹

283. Then Vice Admiral Johnston agreed that the breadth of the discretion to terminate in the armed forces is more extensive than in the civilian sphere.²⁸²

284. Defence needs to be able to self-regulate its workforce. However, it also needs to apply an appropriate balance given the high risks of involuntary separation.

Notice to show cause timeframes

285. A member’s main opportunity to challenge an administrative termination decision is in their response to a Notice to Show Cause. They have at least 14 days to provide that response before a final decision is made.²⁸³

286. Defence emphasises that ‘often a request for an extension to Command is prepared to allow a reasonable time period for the ADF member to receive Legal Assistance’.²⁸⁴ However, that is a matter of discretion.

287. Professor Collins pointed out that:

putting a person in the pressured position of responding to a Notice to Show Cause may result in an unacceptable erosion of their rights to a presumption of innocence or fair process before a service tribunal.²⁸⁵

288. Given Defence’s assurance system failings, it has no means to analyse how often that discretion is used to give a member a time extension.²⁸⁶

289. We heard concerns through submissions and private hearings about the timeframe. This was especially in cases where the prospect of involuntary discharge caused significant distress:

The day after he was discharged from hospital, during which time he was started on several medication and underwent intensive treatment, he was directed to attend [redacted], where he was presented with a Notice to Show Cause (NTSC) for discharge from the RAN [Royal Australian Navy]. This was for an administration discharge, which he was required to respond to within 14 days, to a number of behaviours that command had deemed to be not in keeping with a senior sailor in the RAN. The fact that my partner has only just been released from inpatient treatment, for depression and suicide ideation, had recently started new medication which affected his ability to concentrate and focus, did not seem to be taken into consideration or a care factor for Command. My partner was by no means better or really in the right headspace to receive that information. To present a NTSC at this time, to expect the member to try and respond in an appropriate manner and to try and fight an administration discharge, placed an, in my opinion, an unnecessary strain and stress on my partner... Responding to the NTSC whilst still undergoing active mental health treatment, would often result in my partner wanting to give up. Give up on trying to trying to draft a response and give up on life!!! I spend a significant proportion of that time, convincing my partner not to commit suicide that he was not the “piece of shit” that his Command was trying to tell him he was.²⁸⁷

290. As part of the Vice Chief of Defence Force accountable officer handover pack to the Chief of Personnel, the Director of Defence Counsel Services suggested imposing timeframes for command responses to adverse administrative action. The Director noted that while members have a time limit to submit a response, the decision maker has none for their response:

This can sometimes lead to members waiting for lengthy periods of time before receiving a decision, with the uncertainty in the meantime leading to distress. Mandating response or decision times in policy may relieve some of this uncertainty and support a trauma-informed approach to Command decision-making.²⁸⁸

291. Defence advised as part of our procedural fairness process that the Defence Transition Manual states that a delegate is to decide within 28 days of receiving a matter, after the member has responded.²⁸⁹ Defence agreed that enhanced communication of these timeframes would assist both decision makers and impacted personnel to understand the stage of proceedings and how soon a decision would be made.²⁹⁰

Opportunity for appeal

292. Then Vice Admiral Johnston told us the power to decide to separate an individual from service does not, in most cases, reside with a commanding officer. It rests with the imposing authority.²⁹¹

293. However, Defence witnesses agreed that in the majority of cases, the imposing authority sustained the recommendation for termination and this had been the trend for the last three years.²⁹²

294. An imposing authority has no direct contact with the member.²⁹³ This limits their ability to consider the member's perspective beyond what they review 'on paper'. This is in contrast to a Defence Tribunal process.

295. The termination of a member's service is very serious, second only to imprisonment. Given this, we consider the current process does not allow the imposing authority adequate consideration of the merits of the decision. To strengthen procedural fairness of the process, the ability to appeal decisions, on a merits review basis, needs to be significantly strengthened.

296. Defence argued a broad right of merits review is not available to Australian Government employees and made similar assertions about the Australian Federal Police.²⁹⁴ Defence later noted that:

Limiting options to respond to misconduct would apply an accountability limit on the ADF that does not apply to other organisations.²⁹⁵

297. We do not agree with the comparison between serving members, Australian Government employees and the Australian Federal Police. Public servants can appeal termination decisions externally to the independent Fair Work Commission. Its unfair dismissal jurisdiction assesses whether termination of employment is 'harsh, unjust or unreasonable'.²⁹⁶

298. Police are also unionised and this provides a protective balance of power and a level of advocacy not available to serving ADF members.

299. In his testimony, Judge Humphreys noted the limited options for Defence personnel compared to the mechanisms by which civilians can challenge employment decisions, such as through the Fair Work Commission or on appeal to the Administrative Appeals Tribunal (AAT).²⁹⁷

300. In the case of involuntary administrative terminations, if an ADF member is dissatisfied with a decision, act or omission they may submit a redress of grievance (ROG), which is a formal complaint process.²⁹⁸ The Complaints and Resolutions Manual (CARM) prescribes that a grievance relating to a termination of service decision must be submitted within 14 days after the member was notified of the decision.²⁹⁹
301. Vice Admiral Johnston agreed there should be more scope for discretion to accept a redress of grievance after the member's 14 days to respond has expired.³⁰⁰
302. IGADF can consider redress of grievances if members are not satisfied with a decision for administrative termination, but can only make recommendations and cannot reverse a decision.³⁰¹
303. IGADF reviews focus on ensuring the administrative process has been correctly followed, as opposed to reviewing whether a judgement was made on reasonable and fair grounds.³⁰² For details of this and the redress of grievances, see Chapter 12, Role and functions of the Inspector-General of the ADF.
304. As outlined in that chapter, the information provided to the Royal Commission showed that between 1 January 2020 and 7 July 2023, 190 Redress of Grievance (ROG) complaints about involuntary separation were referred to the Inspector General, with the majority of these (162) related to decisions based on retention of the member's service not in the interests of the Defence Force.³⁰³ Of the 172 complaints which had been finalised, the IGADF decided not to consider or to stop considering the complaint in 89% of these cases.³⁰⁴
305. Members can also lodge a complaint with the Commonwealth Ombudsman. However, the Ombudsman has no ability to compel policy change or administrative action by a government agency or Minister.³⁰⁵ While the Ombudsman is empowered to investigate complaints made to it by current or former ADF members (who have first sought redress from Defence but are unsatisfied with the outcome), it has no power to direct Defence to re-make its decision.³⁰⁶
306. A decision made on administrative grounds may be reviewed by an Australian court for its legality. However, the court must '[take care] not to substitute their view for the view of the Chief of Defence Force as the person designated by law, command and experience to best determine what is in the interests of the ADF'.³⁰⁷
307. Judge Humphreys in Hearing Block 11 highlighted the prohibitive costs involved, and the timeframes, with appeals through the Federal Court:

The issue that I've indicated is that many members simply are unwilling to roll the dice because of the possibility of an adverse costs order. So there may well be matters where there was the possibility that a successful legal challenge could take place, but they're simply not willing to do so and, to be honest, if I was advising a member, I would be very reluctant if they were a private soldier, for example, who has limited financial resources to advise them to go to the Federal Court, even though I might regard their chances of success

as being reasonable. It requires a certain degree of courage; they would be prepared to roll the dice given the fairly strict or very strict criteria to actually get up to actually run a matter.³⁰⁸

308. A veteran legal service submission stressed this point:

It is commonly seen in practice that the ADF can utilise an abundance of human, legal and financial taxpayer resources to minimise liability to itself as an organisation ... The ADF will go to extraordinary lengths to fight cases they really should not be fighting, employing the common tactic to brief a battery of lawyers, including senior counsel to fight cases with a view to scaring victims away from proceeding to trial, and to have enormous costs awarded against them. This is reminiscent of strong-arm tactics that have disastrous outcomes in terms of the mental health of victims.³⁰⁹

309. They included a client's case study, which demonstrated this:

I did not pursue their offer because I could not afford to be embroiled in a protracted legal debate which is what would have resulted. The ADF has a propensity to cash starve anyone attempting to hold the hierarchy to account. The ADF has unlimited financial resources, whereas other Defence members and I do not.³¹⁰

310. We have received submissions which describe members' frustrations with the limitations of current avenues for external review:

When I referred this matter to the Inspector General ADF they struggled to help me as processes were generally followed, even though my case officer said that the processes that [redacted] had invented for themselves were ultimately flawed. There was no outside accountability at all!³¹¹

311. Another submission observed:

Expediting Defence's responses to the DFO [Defence Force Ombudsman] does not enhance the honesty or competency of these responses. Nor does it address veterans' main concern about just how effective is the DFO in examining their grievances even if the DFO decides to examine them at all. Significant trauma is caused to service personal and veterans because their grievances are not adequately resolved in the DFO system...The DFO has no 'bark and bite' powers to investigate improbity and maladministration by the generals.³¹²

312. It can be exceedingly difficult for a member who is in a situation of stress and potential trauma to challenge the ADF's power.

313. Judge Humphreys told us that a right of appeal to the Administrative Appeals Tribunal (AAT) would provide ADF members with a 'fair, just, economical and quick merits review mechanism, which is external to Defence'.³¹³ He acknowledged a potential

‘unwillingness of Command to actually cede that power to an external administrative body’ but argued such a measure was more in step with contemporary Australian expectations.³¹⁴

314. We note that, at the time of writing this report, the government has introduced Bills to parliament to abolish the AAT and establish a new federal administrative review body to be named the Administrative Review Tribunal.³¹⁵
315. We note that Defence recently made some effort to improve guidance for the high risk cohort of members whose retention was not in the interests of the Defence Force. An updated Part 10 of the Military Personnel Policy Manual requires commanding officers to conduct a risk assessment for individual cases prior to separation to account for sensitivities and mitigate unintended consequences. This includes consultation with relevant health staff. The update requires a support officer to be appointed after the decision has been issued, to support mental and physical wellbeing through the separation process.³¹⁶
316. The Military Personnel Policy Manual also now sets an expected transition period of three months for involuntary separations, increased from 14-28 days in previous practice, to mitigate the risk of lack of preparation identified by the Interim National Commissioner.³¹⁷
317. Defence also asked us, as part of the procedural fairness process, to ‘have regard’ to the welfare and legal supports for participants in military justice proceedings as a safe guard.³¹⁸ However, as we highlight in section 10.6.3, Defence has not evaluated the effectiveness of these supports in meeting members’ needs and improving wellbeing. As a result, it is unclear how well these supports are targeted to the unique needs of those subject to administrative or disciplinary action. We have no confidence that this ‘safeguard’ is effective.
318. Defence advised further steps taken to reduce the occurrence of administrative separation as a potential risk factor are as follows:
- enhancing management of multi-mode separations, where there are medical factors as well as reported misconduct
 - increasing focus on understanding wellbeing factors influencing misconduct, so that the number of involuntary administrative separations reduces.³¹⁹
319. We support efforts to improve guidance and policy and support. However, stronger measures are required to ensure those subject to involuntary separation for the reason ‘retention-not-in-service-interest’ have meaningful access to appeal. Focused measures are required to ensure that the desired changes will be realised.

Recommendation 31: Consider how mental health may contribute to poor conduct before recommending administrative termination

That it be mandatory for Defence, when recommending administrative termination of a member under Section 24 (1) (c) of the Defence Regulation 2016 (Cth) 'retention-not-in-service-interest', to consider the member's current mental health and/or the role that mental health may have played in the behaviour that attracted administrative action.

Recommendation 32: When requested, conduct a merits review when a member's service is terminated for the reason 'retention-not-in-service-interest'

Defence should implement a merits-review process for involuntary separation under Section 24 (1) (c) of the Defence Regulation 2016 (Cth) 'retention-not-in-service-interest' through consultation and collaboration with the Inspector-General of the Australian Defence Force (ADF) and the Administrative Appeals Tribunal/ Administrative Review Tribunal.

- (a) Defence should introduce an enhanced merits-review process in the Redress of Grievance Directorate of the Inspector-General of the ADF.
- (b) The Australian Government should consider giving jurisdiction to a specialist division of the Administrative Appeals Tribunal/Administrative Review Tribunal to manage a fast-track method for conducting external merits reviews. It is proposed that an external merits review would only be considered after the independent merits review process of the Inspector-General of the ADF had been completed.

10.5 The discipline system

- 320. Members facing some of the most serious offences, either as victims or accused, will be subject to discipline proceedings.
- 321. A 2017 Chief of Defence Force-directed review of the ADF summary discipline system found it was 'overly complex and disproportionately difficult to use when dealing with minor transgressions'.³²⁰
- 322. Defence reformed summary discipline processes and procedures to meet the Chief of Defence Force's requirement for a military justice system that was easy to use, timely, fair and trusted by members of the ADF.³²¹

323. In 2021, the Judge Advocate General outlined six proposals to improve the discipline system for inclusion in the MJSG work plan. In particular, this included a call for a superior tribunal level.³²²
324. Both the Chief of Defence Force-directed review and the Judge Advocate General proposals prompted reforms to policy, procedure, and legislative amendments, to reduce complexity, provide greater choice, enhance safeguards, expedite processes for minor infringements, and incorporate new service offences.³²³
325. Work continues on reforms in the 2024 work program. We note the proposal for a 'Special Victim Counsel' to provide legal assistance by right to current or former members in sexual misconduct matters in superior tribunal proceedings. The right will arise when the accused seeks access to the complainant's 'protected confidence information', which is a special legal category of personal information.³²⁴

10.5.1 Data relating to the discipline system and suicidality

326. We highlight in section 10.1.2 our analysis that found heightened risk of suicide for some serving and ex-serving members who interact with the military justice system.
327. Ex-serving males who served in the permanent forces and who faced trial:
- for an offence under the Defence Force Discipline Act during service are 2.96 times (196%) more likely to die by suicide than Australian males
 - before a commanding officer or a subordinate summary authority during service are 3.14 times (214%) and 4.76 times (376%) more likely, respectively, to die by suicide than Australian males.
328. Males serving in the permanent forces who faced trial before a subordinate summary authority during service are 2.01 times (101%) more likely to die by suicide than Australian employed males (note results should be interpreted with caution due to small sample size). See Appendix K, Comparative suicide rates and select causes of death, for further detail on different conviction types.
329. The results for women serving in the permanent forces are not reported due to small numbers limiting the conclusions which can be drawn.
330. Ex-serving women who served in the permanent forces who faced trial for an offence under the Defence Force Discipline Act during service are 4.54 times (354%) more likely to die by suicide than Australian females (note that these results should be interpreted with caution due to small sample size). A breakdown of the findings for women who served in the permanent forces and were convicted of an offence under the Act by a summary authority during service have been suppressed due to small numbers.

331. Further analysis is required to understand the relationship between these categories and increased risk of suicide and suicidality, and to identify opportunities to address and reduce the risks underlying these concerning trends. We strongly recommend this work be added to the MJSG workplan.

Recommendation 33: Seek to understand whether/how involvement in military justice processes contributes to adverse outcomes

Defence should undertake further research to better understand the stressors that are both associated with, and lead to, involvement in administrative and disciplinary processes, including:

- (a) identifying prevalence rates of suicide and suicidality for serving and ex-serving members who have been exposed to military justice administrative and disciplinary processes
- (b) exploring the connection between members' use of alcohol and other drugs as a numbing strategy to help them cope with trauma and service-related stressors, and involvement in administrative or disciplinary processes
- (c) identifying opportunities to intervene when members are engaging in maladaptive coping strategies before their behaviour leads to administrative or disciplinary action.

Based on the outcomes of this research, Defence should implement policies to support members involved with military justice processes and minimise the risk of adverse outcomes, including suicide and suicidality.

10.5.2 Areas for improvement

332. We have identified four key issues for particular consideration to improve the discipline system:
- (1) communication between ADF and civilian police about members convicted of an offence in either jurisdiction
 - (2) court martial panels not providing reasons for the punishment imposed, as highlighted in the 2022 Judge Advocate General bi-annual report³²⁵
 - (3) ensuring mental health provisions relating to Defence Force Discipline Act section 145 (dealing with circumstances of unfitness for trial and for mental impairment at the time of an offence) are modernised
 - (4) improving safeguards to reduce potential risk to members' mental health and wellbeing when involved in the discipline system.

Poor communication between ADF and civilian police about convictions

333. Criminal record checks are part of the Defence recruitment process. However, if a serving member is convicted of a serious offence in the civilian justice system, Defence relies on the member advising them of this. It does not have a complete and accurate record of serving members convicted of sexual or other offences under state and territory legislation.³²⁶

334. The Judge Advocate General annual report highlighted concerns that where members are convicted of a Defence Force Discipline Act offence, they transition to civilian life with no recorded civilian conviction. The Act's section 190A enables Defence to disclose the fact of a conviction for a service offence to a Commonwealth, state or territory authority. However, the Judge Advocate General does not believe this has ever been done:

I understand no policy or procedure exists to facilitate its utilisation. In practice this may mean members who are convicted of 'Territory offences' (offences contrary to ACT criminal law prosecuted under s 61 DFDA [Defence Force Discipline Act]), may transition to civilian life after serving the sentence with no recorded civilian conviction.³²⁷

335. We strongly encourage Defence to urgently improve communication with states and territories about members convicted of offences under the Defence Force Discipline Act. It must also improve its communication about members convicted of civil jurisdiction offences, particularly those convicted of more serious offences. We note the risk to the Australian community of not doing so.

336. Chapter 8, Military sexual violence, covers this in further detail, however we are deeply concerned about this lack of visibility and the risk to members as a result of this inadequate screening.

Court martial panels should give reasons for their punishments

337. The Judge Advocate General highlighted concerns that court martial panels are not required to give reasons for the punishment imposed:

Australia is now the only Five Eyes military discipline system retaining the historic system of the court martial panel determining guilt and also determining penalty, and doing so without giving reasons. The practice is anachronistic and contrary to fundamental principles of open justice and fairness. Further, reasons for sentence are crucial to appropriate accountability and contemporary confidence in the military justice system.³²⁸

338. We agree with the Judge Advocate General's assessment. Given the increased risk of suicide for those convicted of offences, we strongly encourage all efforts to improve transparency and accountability in the sentencing process for those convicted of a crime. This includes requiring panels to give reasons.

Slow progress on mental health reforms

339. The history of proposals for modernising the mental health provisions relating to the discipline system is alarming.
340. Six years ago, work began on modernising section 145 of the Defence Force Discipline Act on mental health provisions. This relates to dealing with the circumstances of unfitness for trial and for mental impairment at the time of an offence. Three years later in September 2021, a draft Bill was circulated among stakeholders.³²⁹ However, by the end of that year, the MJSG noted that there were 'no prospects of ... military justice legislation during the tenure of this government, especially mental health reform'.³³⁰
341. In 2023, the Inspector General of the ADF described Defence's current provisions as 'trailing behind civilian legislation'. He called for them to be updated as a priority.³³¹
342. MJSG minutes from September 2023 flagged it intended to re-instate reform to the mental health provisions of the discipline system (fitness to stand trial and mental impairment) as part of the 2024 workplan.³³²
343. As part of our procedural fairness process, Defence advised that a concept paper for comprehensive mental health reform, including diversionary options at summary and superior level, is to be presented to MJSG mid-2024.³³³
344. This will be six years after the issue was first identified, despite numerous reviews focusing on member and ex-serving member mental health and suicide.
345. Six years is too long. In light of the evidence provided in this chapter about links between military justice system processes and suicide, this reform must be prioritised.

Improving wellbeing safeguards for members

346. Many of the administrative system issues we have highlighted that negatively impact on members' wellbeing are relevant to the discipline system and we will not re-prosecute those issues here. These relate to:
- a justice system's inherent stressors for participants, due to uncertainty and its adversarial nature
 - perceived or actual issues with transparency and procedural fairness
 - distress caused by process delays or significantly drawn out timeframes
 - not being kept informed of progress or outcomes.

347. We recommend further safeguards to minimise trauma on those involved in the discipline system in the following sections. These strategies apply to both discipline and administrative systems and relate to trauma-informed practice and support.
348. Chapter 8 recommends improving communication between Defence and states and territories regarding persons convicted of offences either under civilian jurisdiction or under the Defence Force Discipline Act.

Recommendation 34: Prioritise the review into the regulations governing court martial panels

Defence should prioritise the review of current provisions relating to court martial panels not being required to provide reasons for punishments being imposed.

Defence should document this in the 2024/25 Military Justice Steering Group workplan.

Features of good practice

349. We found elements of good practice in reforms made from the 2017 review of the ADF summary system and the 2021 Judge Advocate General proposals to improve operation of the discipline system. Just as it is important to highlight deficiencies, we consider it important also to highlight good practice where it appears.

Curiosity by the reform lead

350. Successful reforms benefit from senior accountability and leadership. A two-star officer led the Summary Discipline Review.³³⁴ Then Vice Admiral Johnston told us it was this officer who identified and raised concerns with assurance, and recommended an independent review be undertaken of risk and assurance in the military justice system to get a better understanding of the issue. This resulted in the 2020 review by Axiom Associates into the Military Justice Assurance Framework. This demonstrated leadership curiosity, where concerns led to a much broader inquiry to establish an evidence base to inform further action and improvement.³³⁵

Regular agenda items and updates

351. Status reporting of the summary discipline reforms and Judge Advocate General proposals are regular features in the work plan and on the MJSG and Military Justice Assurance Framework agendas. Their implementation is consistently tracked and discussed at consecutive meetings.³³⁶ We noted a greater clarity around timeframes and performance than we have seen in other areas.³³⁷

Performance monitoring

352. The summary discipline reforms benefited from tracking against targets and routine monitoring and reporting of timeliness against targets. All reform elements provided analysis of performance based on the data available, however limited the data was in some areas.³³⁸
353. We noted the 2023 Chiefs of Service Committee update included an inadequate capacity to analyse statistics to better understand potential causative and correlative factors that may contribute to performance delays.³³⁹ While we note the challenges, we commend the ongoing efforts to monitor, measure and improve performance in the face of limitations.

Iterative processes

354. We noted how approaches to issues were updated in response to performance analysis. For instance, there were discussions over several meetings about the digitisation of discipline records, how data could be used for assurance purposes and the need to harmonise the Summary Discipline Dashboard with CASE.³⁴⁰ Processes or approaches were changed in each case.
355. Similarly, the High Court case of *Pte R v Cowen* was unfolding throughout 2021 and 2022. Because this case had implications for the scope of the military justice jurisdiction, it was routinely discussed in the context of the Judge Advocate General's suite of reforms and approaches adapted.

10.6 Embedding trauma-informed practice

356. Taking a trauma-informed approach includes having systems, policies and practices in place that have regard for the nature of the trauma that individuals are experiencing, and minimise the impact of inherently stressful investigatory and prosecution processes. Through understanding how that trauma can impact individuals, as well as being able to recognise the symptoms and signs of that trauma in individuals, the individual's needs can be put at the centre of the response and so avoid re-traumatising them.³⁴¹
357. The then Vice Chief of the Defence Force, Admiral Johnston, described trauma-informed practice as follows:

Commissioners, in my view, it means conducting the entire inquiry with a view to the trauma involved to all parties in it, the claimants, the respondents, the witnesses that are involved in it. So it means adopting an approach where the manner by which they approach their engagement with all parties is informed by that understanding of this, that these are often stressful inquiries for everybody involved, the language that they use, the manner by which they form their conclusions. Particularly important is the way that they write and submit their findings and recommendations. And then it will be important, and the inquiry manual now accommodates it with the changes, in terms of how information is provided back to all parties, both through the conduct of the inquiry and at its end.³⁴²

358. Major General Stothart in Hearing Block 11 recognised the importance of being trauma-informed and acknowledged the challenges of implementing this in practice.³⁴³
359. Justice processes are inherently stressful, and even where someone is not experiencing trauma, the nature of the system can create or significantly increase distress.
360. In this section, we examine the ADF processes that could be improved to minimise further distress on those who are subject to military justice action.

Recent amendments to policy to improve trauma-informed practice

361. Since at least 2019, Defence has recognised the importance of, and engaged in some trauma-informed practices, relating to military policing and restorative engagement.³⁴⁴
362. More recently, Defence has amended some of its policies, as well as introduced new policies, with the aim of further improving trauma-informed practice in these areas, which we consider in this section. These reforms notwithstanding, Defence acknowledges that more strategies are needed to ensure that policy is translated into practice and action.³⁴⁵
363. Defence policy reforms or proposals for reform to encourage a more trauma-informed approach include:
- The Sexual Offence Response Unit (SORT) engagement with potentially vulnerable witnesses is focused on ensuring that person's physical and emotional safety during their engagement with JMPU investigative processes, and supporting their decision-making.³⁴⁶
 - In early 2024, the MJSG endorsed a new policy proposal, first put forward in 2023, to safeguard against the risks of harm that may arise for witnesses in Defence Force Discipline Act proceedings where their personal information is disclosed to the accused person through lawful discovery processes.
 - In February 2024, Defence published a plain language policy on the notification of outcomes in the Complaints and Alternative Resolutions Manual (CARM). The new chapter sets out information and principles for commanders and managers on who must be notified, what information is usually to be notified (including the type of action taken) and how it should be notified.³⁴⁷
 - The Administrative Inquiries Manual was amended in October 2023 to include guidance on a trauma-informed approaches to inquiries.³⁴⁸
 - We previously noted Defence's work to scope the introduction of 'Special Victim Counsel' to provide legal assistance by right to current or former members in sexual misconduct matters in superior tribunal proceedings.³⁴⁹
364. Further, we note that the minutes of the February 2023 MJSG meeting outlined a detailed discussion regarding mental health and the intention for more 'trauma-informed' processes in the military justice system as identified through a policy gap analysis.³⁵⁰

365. Discussion focused on the need to update policies, noting the ad-hoc arrangements that Defence uses without formal guidance.³⁵¹ Suggestions in that meeting also included reducing requirements on a victim having to recount their evidence more often or to more people than is necessary and an early concept for a diversionary program was in development to deal with low level issues.³⁵²
366. We sought an update from then Vice Admiral Johnston in Hearing Block 12 about whether that policy gap analysis had progressed. He was unable to confirm, but did allude to some other work the MJSG had been progressing around legislative amendment regarding fitness for trial and fitness for administrative action (discussed earlier in this chapter) and a directive about the role medical practitioners should play in military justice.³⁵³
367. We strongly encourage the MJSG to revisit how these items might be progressed as actions in 2024 and 2025.

Effectiveness of trauma-informed policy

368. While Defence has made efforts to improve trauma-informed policy, it is unable to monitor if policies are consistently applied, nor is it able to monitor if policies are effective. In Hearing Block 12, Vice Admiral Johnston acknowledged limitations in the mechanisms to assure that trauma-informed policy and practice is being implemented as intended.³⁵⁴
369. Defence also asserted as part of the procedural fairness process that the recent amendments to policy mean that it is too early to assess the effectiveness of these measures, and this will be a focus for the next stage of implementation, which is assurance.³⁵⁵
370. Below, we cite four examples where it is apparent that Defence did not act in a trauma-informed way. We acknowledge that the recent amendments referred to above occurred after these cases. However, these examples highlight that it is important for the voices of lived experience to be heard to ensure that Defence does not lose focus on continuing to improve its responses.
371. In section 10.2.2 we provided an overview of our in-depth inquiry which highlighted a range of shortcomings in trauma-informed practice for the witness, and the significant impact of these oversights on the mental health and wellbeing of that witness. The December 2023 MJSG minutes acknowledged the impact and subsequent actions:

The 2022 Royal Commission into Defence and Veteran Suicide (RCDVS) In Depth Inquiry (IDI) heard lived experience testimony about the lack of trauma-informed approaches to administrative inquiries in Defence ... Following the IDI, Defence self-identified several initiatives to improve guidance on the appointment of conduct of inquiries and to address a specific consideration in the definitions of unacceptable behaviour in CARM ... to avoid similar experiences re-occurring.³⁵⁶

372. In Hearing Block 12, we also heard from ex-serving member, Mr John Armfield, who served for over 20 years. He spent the first 15 years as a Navy Clearance diver and received a number of commendations and awards during his service.³⁵⁷
373. In 2011, Mr Armfield's younger brother, who was a serving member in the Army, died by suicide.³⁵⁸ In 2021, ten years later, Mr Armfield received a letter from the Chief of Staff of the ADF Headquarters in relation to the inquiry into his brother's death.³⁵⁹
374. Mr Armfield was unaware there had been an inquiry and had to navigate a number of approvals to obtain a copy of the report of the inquiry. It was sent to him in the mail, with no supports put in place to help him navigate the confronting content.³⁶⁰
375. When Mr Armfield lodged a complaint about the inquiry into his brother's death, including how information of the suicide was managed and communicated to him, and a complaint about aspects of his own treatment, he was accused by his commanding officer of lodging a subjective and emotive complaint.³⁶¹ Mr Armfield highlighted:
- It is the mental health lady who supported me the entire time, and I appreciate it, she's here, from the Royal Commission, she goes, 'It should be subjective. It should be emotive. This is your little brother'.³⁶²
376. Mr Armfield later requested a record of conversation with his chain of command regarding a privacy breach relating to his complaint.³⁶³ He was instead accused of unauthorised access to a defence system, about which he received a letter advising he was facing serious criminal charges.³⁶⁴ Upon later review by the IGADF, this was found to be unsubstantiated.³⁶⁵ However, from 14 December 2022 to 4 August 2023, Mr Armfield had been expecting to be charged. He had been given no updates or support during this time, which caused him immense distress:
- ... I was in a very, very bad place. No one sat me down [to] help with staff documents. No one told me how to go about this and, as per the evidence I've provided and the emails, three officers knew that I had an issue with the maladministration and yet nothing was done to support me.³⁶⁶
377. Lieutenant Colonel Paul Morgan (Retd) gave evidence about his experiences with the military justice process. Colonel Morgan spent 20 years in the Army as a psychologist. He had been in the Army for around 14 years when, in 2010, he received a death threat. An online anti-gay hate site using the Australian Army emblem named him and five other soldiers as being gay.
378. Colonel Morgan's evidence about the Defence response over the next ten years highlighted a complete absence of any trauma-informed focus:
- (a) Defence did nothing in response to his informing them of the death threat, and put no protective measures in place.³⁶⁷
 - (b) He reported the May 2010 email death threat to Defence, but was not told by Defence of the online anti-gay hate-site, even though his commanding officers knew of it.

- (c) When he made a verbal complaint, the senior person in his chain of command asked whether he had ‘considered the consequences of making an Unacceptable Behaviour complaint, which he outlined to the effect of “career death”’.³⁶⁸
- (d) It took 290 days before the first respondent was interviewed by Australian Defence Force Investigation Service, and it took 441 days for the service to complete the investigation.³⁶⁹ The excessive delay ‘ultimately led to an exacerbation of psychiatric injuries’ and increased his ‘suicidal thinking and behaviour’.³⁷⁰
- (e) When he became aware of delays and inaction in managing the unacceptable behaviour complaint, Colonel Morgan communicated he would lodge a formal complaint with the Australian Human Rights Commission. He ‘was ordered by a Warrant Officer in ADFIS [Australian Defence Force Investigation Service] not to communicate with the Human Rights Commission – when he invoked the powers of the Provost Marshall of the ADF to limit my communications regarding those involved’.³⁷¹

379. Colonel Morgan’s experience included lodging redress of grievances and appeals through the IGADF to ensure procedural fairness in how the complaint was investigated, given he perceived a conflict of interest in a member appointed to the initial inquiry:

I was trapped in a system that would not protect me from harm or act fairly or in accordance with the principles of natural justice or indeed the law. I had significant concerns for my physical safety at work and at home – and Defence seemingly could not comprehend the likely link between the death threats I had received at work and the Facebook and YouTube sites that had identifiable members of the ADF that I was meant to interact with.³⁷²

380. Colonel Morgan left the ADF in 2017 on mental health grounds.³⁷³

381. In Hearing Block 11, we heard from Reverend Dr Coleman, who joined the Air Force in 2017 as a Chaplain.³⁷⁴ Reverend Dr Coleman was subjected to physical and sexual harassment and assault, serious bullying, abuse of power and threats of administrative and disciplinary action by a superior.³⁷⁵ Reverend Dr Coleman told us of her experience in trying to report unacceptable behaviour:

- (a) A commanding officer actively discouraged her from formally reporting the behaviour due to the impact on the accused, and the importance of keeping matters ‘in house’ and such action (reporting) being contrary to Christian principles.³⁷⁶
- (b) Her superior was informed of her informal complaints and the bullying escalated.³⁷⁷
- (c) She was denied legal support or advice to assist her in preparing her complaint and was advised the role of legal officers was to provide legal advice to command, not members.³⁷⁸

- (d) No alternative wellbeing support was offered, given the Air Force chaplaincy program was not appropriate as that was Reverend Dr Coleman's workplace and subject to the complaint, until Reverend Dr Coleman requested an Army Chaplain be assigned.³⁷⁹
 - (e) Reverend Dr Coleman's attempts to be relocated so she did not have to continue to work with the accused while the complaint was investigated were repeatedly denied.³⁸⁰
382. The testimony and statements of these witnesses demonstrate that in these cases, Defence did not act in a trauma-informed way, resulting in significant harm to these individuals, including suicidal thoughts. This emphasises the importance of ensuring trauma-informed practices are embedded within military justice processes.
383. More is needed beyond policy and procedural amendment, as identified in the Commonwealth Ombudsman's report *Defending Fairness: Does Defence handle unacceptable behaviour complaints effectively?* and in Defence briefings regarding inconsistent application of the administrative system.³⁸¹ Policy alone will not drive meaningful and impactful change.
384. As part of the procedural fairness process, Defence advised that it has introduced Trauma Informed Practices training that is available for all personnel.³⁸²
385. The next sections consider some of the key safeguards to improve support and reduce trauma on members subject to the military justice system.

10.6.1 Legal support services

386. Access to independent, competent and efficient legal support services is an important safeguard in improving wellbeing outcomes for those involved in the military justice system. It supports procedural fairness by assisting members to navigate a complex and adversarial system.
387. Types of legal services include legal assistance and legal representation (with the latter being a sub-category of the former).³⁸³
388. 'Legal assistance' refers to legal services provided to individual ADF members. For most legal assistance arrangements, there is a lawyer-client relationship where the member retains primary responsibility for a legal matter and is provided with specialist legal advice to guide the conduct of the matter.³⁸⁴
389. 'Legal representation' refers to a lawyer-client relationship where the lawyer takes carriage of the legal matter in an ongoing, representative capacity.³⁸⁵ Legal representation is provided in limited circumstances, where the ADF member:
- is subject to trial by a superior service tribunal (Courts Martial or Defence Force Magistrate); or
 - is likely to be materially adversely affected by a Commission of Inquiry.³⁸⁶

390. Defence advises that, in general, ADF members receive free legal assistance via the Defence Counsel Services (DCS) to deal with internal service-related matters. They receive an hour of legal assistance for non-service related matters.³⁸⁷ This is usually provided by military lawyers who are Reserve members.³⁸⁸
391. DCS is responsible for providing legal assistance to ADF members, while the Defence Legal Division (Defence Legal) provides legal advice to the ADF, the Minister for Defence and the Department of Defence.³⁸⁹
392. For Defence Counsel Services legal officers, the primary client is the member to whom it owes legal professional duties, including confidentiality and protection under Legal Professional Privilege.³⁹⁰ Confidential records and communications cannot be disclosed unless the client decides to release them.³⁹¹
393. DCS is independent of the chain of command and reports directly to the Associate Secretary of Defence.³⁹² The Director of Defence Counsel Services reports twice a year (or otherwise as directed) to the Associate Secretary concerning the performance of their functions.³⁹³
394. In October 2023, the Associate Secretary approved the re-structure for DCS to operate as an independent division without needing to rely on Defence Legal for Australian Public Service staffing and operating budget resourcing. This included approving the transfer of staff and budget, as requested by the Director of DCS, to finalise the transition and enhance the independence as intended by a 2020 review which sought to improve the independence of the DCS.³⁹⁴
395. In Hearing Block 12, then Vice Admiral Johnston considered the importance of this request in supporting perceived and actual independence. He agreed that, while ensuring members perceived its independence was important, its actual independence is necessary to enhance the impartiality of the military justice system.³⁹⁵ DCS expects to achieve its status as an independent division by end of June 2024.³⁹⁶
396. As part of the restructure, a DCS manual will be published by late 2024 that will formalise the DCS governance framework and quality assurance mechanisms.³⁹⁷ These are important steps in ensuring that this critical safeguard is performing at its best.
397. The legal officers within the section of Defence who support those subject to the military justice system should not sit within the same section of the department as the lawyers who provide services to Defence in prosecuting those individuals. Nor should DCS be required to rely upon lawyers seconded from Defence Legal.

Overview of legal assistance provision to members

398. The functions of the Director Defence Counsel Services are prescribed by section 110ZB of the *Defence Act 1903* (Cth) and appear to be focused on a trial or court martial under the *Defence Force Discipline Act 1982* (Cth).³⁹⁸

399. The Chief of Defence Force issued a directive under the Act's section 110ZB(1)(e), Directive 02/2023. It gives the Director Defence Counsel Service additional functions, including providing legal assistance to all ADF members and former ADF members, where applicable and within available resources.³⁹⁹

400. Defence advised us that members may request legal assistance at any stage of a military justice matter. It advised 'legal assistance at Commonwealth expense is available to ADF members for Service-related legal issues to the extent required for the matter at hand', 'where applicable' and 'within available resources'.⁴⁰⁰

401. Legal assistance for former Defence members is discretionary and determined on a case by case basis, depending on the nature of the request for legal assistance. As a general guide, legal assistance is made available to former Defence members in relation to internal service related matters.⁴⁰¹ As Defence advised:

If a Defence member, or former Defence member, is charged under the *Defence Force Discipline Act* Cth (1982), they would receive legal representation for their appearance before a superior tribunal (eg Defence Force Magistrate or Court martial). Where there is an Inquiry under the *Defence Inquiry Regulations* Cth (2018), such as a Commission of Inquiry, or an inquiry under the *Inspector-General Australian Defence Force Regulation* (2016) and a former Defence member is required to attend as a witness, they would be provided legal assistance.⁴⁰²

402. In the administrative system, the Director of DCS advised that assistance is provided to an ADF member:

- who has received notice of proposed action against them, including responding to a Notice to Show Cause of any kind (termination, reduction in rank, formal warning, censure, removal from course, removal from command or position, return to Australia, suspension from duty, medical separation notice, Australia Government Security Vetting Agency removal of security clearance)⁴⁰³
- responding to a Notice of Potentially Adverse Findings as part of a fact-finding activity, administrative inquiry or inquiry pursuant to, for example, the *Inspector General of the Australian Defence Force Regulation 2016* (Cth) (IGADF Regulations).⁴⁰⁴

403. Advice about their rights and obligations is also provided to an ADF member involved in, or affected by, a fact-finding or inquiry process.⁴⁰⁵

404. DCS also offers assistance for other issues, complaints or applications arising out of an ADF member's service. These include, but are not limited to, release of information under freedom of information, privacy concerns, redress of grievance and unacceptable behaviour issues.⁴⁰⁶

405. Defence has confirmed that the provision of legal assistance is not a right in all circumstances, such as where matters fall outside statutory rights under the *Defence Force Discipline Act 1982* (Cth), *Defence Act 1903* (Cth), the *Defence Force (Inquiry) Regulations 2018* (Cth), and those matters limited by policy.⁴⁰⁷ Examples include advice regarding civil compensation or damages claims against the Commonwealth, advocacy in relation to any civilian legal matter, and commercial law advice.⁴⁰⁸ Moreover, '[o]perational circumstances may dictate that Legal Assistance is not reasonably available.'⁴⁰⁹
406. When prompted for further information regarding the meaning of 'reasonably available' legal support, Defence advised that this may include:
- (a) operational circumstances such as in a war like environment for deployed members, the security environment, mission timeframes, and the requirement for Command to balance competing interest between ensuring access to legal assistance for ADF members against the operational effect for their task⁴¹⁰
 - (b) limits on time or availability of a legal officer with the requisite clearances or expertise, noting legal assistance may be delayed as opposed to denied⁴¹¹
 - (c) when ADF members contact Defence Counsel Services with a very short turnaround due date for complex and urgent matters that does not give the allocated legal officer time to comprehensively review the material and receive instructions.⁴¹²

Members' experiences of legal support

407. Some submissions we received included accounts of members' difficulty in accessing legal support, or being pressured to accept charges and not defend themselves. One said:

I requested a lawyer to assist with a redress which Headquarters Surveillance Response Group (HQ SRG) said they could not provide. I was dumbfounded as to how a process with such a huge implication on my life could be left completely for me to solve. Again I reached out to my support network, I was lucky enough to have a friend who worked for a service chief. After she told the 3-star officer what was happening I received a begrudging phone call from HQ SRG admin staff saying a lawyer had been allocated and they chided me for 'going above their heads' to do so. I'm not really sure how else I would have been able to get Air Force legal representation.⁴¹³

408. Another member reported dissatisfaction with the quality of support provided:

I was told that I was to be given a C2 Charge for 'Absence from duty' and was expecting to front some kind of discipline from the Commanding Officer. I was given a defending officer, a Corporal from the Regiment, that told me to take the charge and plead guilty or the consequences are much worse if I say I'm innocent

but found guilty. And that it was less work for him if I just went along with it. All I was thinking at the time was, I have not done anything wrong, and I'm not a fault in any way.⁴¹⁴

409. Warrant Officer Class 1 Brian Buskell OAM CSM and Major Tony Kennedy OAM, a Transfer and Transition Detachment Commander, told us at Hearing Block 5 how recent changes to legal officer services resulted in more time-consuming referral processes and the loss of direct interactions with the legal officer.⁴¹⁵ Warrant Officer Buskall highlighted frustrations with the availability and time constraints relating to Reserve Legal Officers.⁴¹⁶
410. If a member is dissatisfied with the legal assistance they received, their avenues for complaint include the legal officer's supervisor, the member's chain of command, directly approaching the Director of Defence Counsel Services, directly approaching Defence Legal, or going to the Minister for Defence.⁴¹⁷ Complaints may also be made externally, through the relevant state or territory law professional body where the legal practitioner is registered.⁴¹⁸
411. As at December 2023, the number and types of complaints made against a DCS Reserve Legal Officer are captured in the DCS bi-annual report to the Associate Secretary for transparency purposes.⁴¹⁹
412. Between 24 October 2021 and 24 October 2023, DCS received 20 complaints regarding the quality or timeliness of the service provided.⁴²⁰ Defence reported that of these 20 complaints:
- eight related to delayed or no response for assistance, with three requests denied due to short timeframes, one of which related to administrative termination
 - six related to both delays in requests for assistance and the quality of assistance provided
 - the remaining six related to complaints about the quality of assistance provided, noting that some of these complaints were connected to dissatisfaction with the outcome of the administrative or legal process.⁴²¹
413. DCS advised us that it relies on policy, training and qualifications to enforce professional standards of DCS Legal Officers. It does not rely on a complaint being made first.⁴²²
414. DCS also tracks service delivery through the use of a range of spreadsheets and discussion at weekly internal meetings.⁴²³ Trends are considered on a monthly basis and through bi-annual reporting to the Associate Secretary. Timeliness is assessed through key performance measures to ensure DCS achieves its mission of providing trusted, independent advice to ADF and former members.⁴²⁴

415. We note that this monitoring is unlikely to identify issues of service quality. Defence advised that DCS had not conducted surveys to obtain feedback from ADF members or former members. However, it was, at the time of drafting this report, scoping the most efficient method of surveying members to better understand quality of service delivery.⁴²⁵

Trauma-informed practice in DCS

416. Asked about its trauma-informed practice in legal assistance, Defence said:

with the exception of policies on Compensation for Detriment cause by Defective Administration claims (CDDA), the policies do not contain specific reference to trauma-informed practice. However, Defence considers that the underpinning concept of Legal Assistance, which is to provide support to members to navigate complex Defence systems including systems of complaint and review, is itself an appropriate support for potentially traumatised and/or vulnerable people.⁴²⁶

417. This statement gives us little confidence that service is being delivered in a trauma-informed way. Interaction with legal systems has been described as a stressor in civilian systems. In a 2019 article on abuse survivors, the authors said, 'Reasons for not seeking legal services post-assault may be justified given many survivors' negative experience with agents of the system'.⁴²⁷
418. However, Defence's position on this appears to have shifted. As part of the procedural fairness process, Defence advised that the following measures are being implemented in DCS to improve trauma-informed approaches:
- Additional mandatory training (Compassionate Foundations) was implemented in the first quarter of 2024 for all DCS staff and Reserve Legal Officers, to complement group training delivered to staff by Blue Knot in February 2024.
 - DCS will continue to conduct trauma-informed training annually to refresh ongoing staff and induct new staff.
 - DCS is currently developing a DCS Manual, which will include trauma-informed practices.⁴²⁸
419. The intended quality assurance processes outlined in the previous section will also assist Defence in better understanding how DCS services are, in fact, delivered in a trauma-informed way.

Resourcing and independence of the Defence Counsel Service to meet demand

420. It is critical that DCS is both independent and adequately resourced to provide Defence members with appropriately specialised, timely and comprehensive legal advice. This is especially so for members interacting with the military justice system.

421. DCS Legal Assistance Statistics from 1 July 2023 to 31 December 2023 showed there 968 service-related and 255 non-service related requests received (a total of 1,223) during that period.⁴²⁹
422. The 968 service related requests consisted of 358 notices to show cause, 67 redress of grievance, and 543 other service related matters. The latter included Joint Military Policing Unit investigations, Defence Force Discipline Act matters and various IGADF inquiries and complaints.⁴³⁰ Of the 358 notice to show cause requests, 112 (31%) related to termination.⁴³¹
423. The ADF relies heavily on reserve legal officers who made up three quarters (75%) of the DCS workforce, as at April 2024.⁴³² This reliance on legal reserve panels can be problematic, given they also have civilian legal commitments. It is further complicated by the Reserve service days provided to each Reserve legal officer by their respective service.⁴³³
424. While Defence has not reported instances where a defence member has been unable to access specialised support from a legal officer, we remain concerned that this can occur where DCS is directly reliant upon unstable resourcing. As highlighted in the previous section, the absence of evaluation of service quality to date makes it difficult to confirm if this is an issue for members.
425. The Director of DCS reports that he manages these limitations by seeking approval from the Military Legal Service accountable officer to access other reserve legal officers not on the DCS panel. The Director told us that despite the limitations, the model has benefits including the specialised skill sets required for such a diverse range of requests for advice and in particular, their civilian law expertise and experience. The demand for legal assistance has ebbs and flows that can be met by allocating work to Reserve legal officers on an 'as needed' basis. Otherwise, having a standing complement of permanent military legal officers would see them otherwise employed to support command.⁴³⁴
426. The Director said there is a risk with current staffing levels in meeting requests during 'surge periods'. Surge periods include responses to key incidents or significant inquiries.⁴³⁵ Due to the recent restructure, and budgetary implications of converting contracts to ongoing Australian Public Service (APS), DCS is currently three APS 4 Administrative Officer positions short of the optimum workforce to meet current and expected levels of legal assistance.⁴³⁶ There is limited capacity to cover staff leave, medical absences, and courses/professional development.⁴³⁷
427. We encourage Defence to provide additional permanent staff (and associated funding) with specialisation in the processes of the military justice system.
428. We also encourage Defence to prioritise the formalisation of quality assurance processes for DCS to ensure ongoing assessment of the extent to which services are meeting members' needs, including the delivery of a trauma-informed service.

10.6.2 Wellbeing support

429. Wellbeing support is important for helping members through inherently stressful processes. Members involved in military justice matters are able to access support through Defence's general wellbeing pathways, including Chaplaincy, Defence Members and Family Support, the Employee Assistance Program, external hotlines like Lifeline and Open Arms, and medical and psychological supports through Joint Health Command.⁴³⁸
430. However, with the exception of the Sexual Misconduct Prevention and Response Office (SeMPRO), none of these services have a specific focus on supporting members through military justice processes, which have unique stressors. Those services that appear to be more relevant to those going through the military justice system are:
- The Workplace Behaviour Adviser Network: an informal system offering support in the event that a member is subject to actual or threatened action. This service allows members to seek assistance in understanding and applying unacceptable behaviour policy and identifying options for resolving conflict at the most appropriate level.⁴³⁹
 - SeMPRO: a victim-focused service staffed by psychologists and social workers trained to respond to sexual misconduct trauma. This service provides immediate and confidential help for those impacted by sexual misconduct.⁴⁴⁰
 - Support Officers (SOs) are allocated to a member when the member is notified that they are involved in administrative, disciplinary or criminal processes.⁴⁴¹ The member must either agree with the appointment of the support officer, decline the requirement for a support officer, or request an alternative support officer in writing.⁴⁴² Support officers do not require any formal training and are not to have a role in the inquiry process or investigation.⁴⁴³
 - Service-specific supports including:
 - The Navy Personnel Support Unit, for members who have 'multifaceted personal issues', such as legal matters arising from service, to a degree that compromises their performance. Support can include return to work planning, risk management, and discharge support.⁴⁴⁴
 - Air Force Member Support Coordination Office, which provides support to Command as well as to members facing complex wellbeing issues including legal matters arising from service.⁴⁴⁵
431. When asked about supports, the Army pointed to commanders' general responsibility for wellbeing. It did not provide anything Army-specific for military justice matters.⁴⁴⁶
432. The then Chief of Defence Force, General Angus Campbell, highlighted the support officer role as a key support mechanism for members who are under either disciplinary or administrative review. He gave testimony in Hearing Block 12 that a member had a designated support officer to provide some degree of continuity in wellbeing support.⁴⁴⁷

433. Defence advised via notice that individual welfare boards can be used to manage the welfare of members involved in legal matters arising from service, particularly when a member is undergoing treatment or throughout a military employment classification review process.⁴⁴⁸
434. Chief of Personnel, Lieutenant General Natasha Fox, told us during Hearing Block 12:
- when we're looking at people who are within the military justice system, or experiencing parts of it, sometimes people are being held to account for their behaviour. It is supporting those people with the right services, as well as victims in the military justice system, so it's making sure both areas are supported and have support officers. Now, there's documentation around that and we are meant to be doing welfare boards around that as well. So they're degrees of assurance in a command chain about managing people to bring a case management approach to the person that is in or could be in a complex military justice situation.⁴⁴⁹
435. Individual welfare boards are discussed further in Chapter 5, The military employment classification system and medical separation. They involve the coordination of a 'holistic workplace management plan' for the member and their family, in communication with the chain of command.⁴⁵⁰ However, Defence conceded that individual welfare boards can be 'intimidating' rather than supportive for members especially if they are dealing with physical and/or mental health issues.⁴⁵¹ There has been no evaluation of the effectiveness of individual welfare boards or wellbeing supports in general, as will be highlighted later in this section.
436. Then Vice Admiral Johnston accepted that one responsibility of the Accountable Officer for military justice should be that they are satisfied the military justice system is not psychologically harming its members. He said the incumbent Chief of Personnel was well positioned to have oversight of how mental health, wellbeing and non-legal support is applied at a systemic level to ensure psychosocial risks are managed.⁴⁵²

Accessing support services through the military justice process

437. We consider Defence's approach to supporting members engaged with the military justice system can be improved. This is particularly in light of the evidence of engagement with the system's processes as a risk factor in suicide and suicidality.
438. In the civilian jurisdiction, there are targeted support services for those involved in justice proceedings. These services provide access to counselling and therapy, as well as various avenues for practical and other support to assist individuals to manage their welfare through an inherently stressful process.

439. The Centre for Innovative Justice at Robert Menzies Institute of Technology in Victoria summarised what was important in victim support services:

When victim support services are effective, they assist victims to manage the impact of the crime they have experienced. This includes understanding and participating in relevant criminal justice processes, as well as a range of other material, psychological, physical and legal recovery needs that may arise as a result of a person's experience of victimisation. For some victims of crime, a lack of effective support can mean that they do not have the opportunity to participate meaningfully in the criminal justice process. Other needs, when not addressed, are also likely to escalate or become protracted. This makes it more difficult for the person to recover and, where possible, return to living the lives in the way they did before their experience of victimisation.⁴⁵³

440. It is not good enough that access to support in the military justice system context is generalised, except for sexual misconduct matters. Nor is it satisfactory that access is dependent on the action of the chain of command and/or the member's knowledge and ability to advocate for themselves.
441. Chapter 15, Promoting health and wellbeing among ADF members, identifies the barriers to help seeking, and the challenges with stigma in members requesting assistance.
442. The Military Personnel Policy Manual states that members are entitled to 'seek the assistance' of a unit support or legal officer when responding to a notice to show cause.⁴⁵⁴
443. The *Administrative Inquiries Manual* indicates that in cases of death, serious injury or unacceptable behaviour matters, members must be offered counselling services.⁴⁵⁵
444. However, in other instances, command is simply encouraged to consider support needs and point the member towards resources. The *Administrative Inquiries Manual* advises that 'the Appointing Authority, inquiry officer or COI President should remain aware of the potential need for welfare support to be provided to witnesses and other participants involved in the inquiry'.⁴⁵⁶ We note this section's use of the word 'should', not 'must'.
445. Defence advised us:

mental health, wellbeing and other non-legal supports are available to all ADF members at any time when they need assistance and support. This is not limited to circumstances following exposure to the military justice system and members are aware of these services through communications and training throughout their ADF service career.

When members are issued with written notification of potential infringements or involvement with the military justice system such as through a Notice to Show Cause or Infringement Notice, this also contains information on support services.

Commanding Officers will also verbally discuss support services during the briefing with the individual about the notice and do so in a balanced and trauma-informed way.

Therefore, in rare instances where the Chain of Command does not identify the need for the member to access such support or otherwise does not take steps to enable the member to access it, the member will have knowledge and access to the supports available to them already.⁴⁵⁷

446. However, evidence provided to us showed this claim of ‘rare instances’ was aspirational. Commanding officers are not consistently identifying members in need of support, or having trauma-informed conversations. We agree with the Commonwealth Ombudsman’s observations in the 2023 *Defending Fairness: Does Defence handle unacceptable behaviour complaints effectively?* report. In it, the Ombudsman said trauma-informed practice is inconsistently applied within Defence and Defence needs stronger internal quality control and assurance mechanisms beyond audits and complaints.⁴⁵⁸

447. A January 2021 to September 2022 *Analysis of IGADF Military Justice Performance Audit Reports* identified that in the administrative system, 23.5% of all general administrative recommendations related to improving support. The most common recommendation was that units should ensure members involved in administrative, disciplinary or criminal processes, whether as complainant or respondent, have a support officer appointed in writing.⁴⁵⁹

448. The November 2023 final report to the Deputy Prime Minister and Minister for Defence by the Afghanistan Inquiry Implementation Oversight Panel by Dr Vivienne Thom AM, Mr Robert Cornall AO, and Professor Rufus Black considered the broader implications of the cultural issues that led to the Afghanistan War crimes and the relationship with abuse in Defence.

449. The panel highlighted the similarities with the Defence Abuse Response Taskforce’s findings about sexual abuse, physical abuse, sexual harassment and workplace harassment and bullying in Defence, noting that:

The Taskforce also found that the chain of command often disregarded its obligations to the person who had been abused and provided little or no assistance.⁴⁶⁰

450. We heard repeatedly, through submissions and in hearings, including from Defence witnesses, that there is no consistency in how commanding officers provide support. This includes identifying the need for support or facilitating it, and whether they hold trauma-informed discussions.

451. Mr John Armfield highlighted the lack of support in his experience:

So the entire time when people talk systems and processes, they are there for the organisation and the reputation of the organisation. But there is ... there was nothing for me. And people go, you know, you've got different organisations here and there, but there was no one to actually champion my cause, there was no one to call this out.⁴⁶¹

452. Air Commander Patrick Keane confirmed that commanders may refer members to psychological support when interacting with the military justice system; however, he noted that it was not standard procedure. It was reliant on the member requesting it, or the commander being able to recognise 'factors' that might warrant further curiosity regarding a member's wellbeing.⁴⁶²

453. We have heard multiple accounts of members not feeling supported when involved with the military justice system.

I was involved in an alcohol related incident which saw me being investigated for 17 months for offences under the *Defence Force Discipline Act* that I did not commit. My unit failed to adhere to Chief of Army Directive 27/09 and provided no welfare support to myself or my family during this period, instead choosing to relentlessly pursue a conviction regardless of the affect the process was having on the soldier or his family ... By this time I was self medicating with alcohol and struggling with depression, instead of providing a support officer throughout this process my unit simply doubled and even tripled my workload whilst I was being investigated, hoping I would break, and I did ... whilst my commanders did not succeed in having me found guilty of the offences, they did succeed in destroying my family unit.⁴⁶³

454. An ex-serving member noted minimal support through their military justice system experience, and its subsequent impact:

I am a Soldier who was dismissed from the ADF for an offence that I plead guilty to and do not deny happened. I was summarily punished by a DFM [Defence Force Magistrate] and was told to leave the Army immediately the case was ratified, there was no entitlement, minimal support [from] ADF and further most no recognition of my previous service due to policies apparently. This complete separation left me in a dark place.⁴⁶⁴

455. Another member expressed their frustration at the lack of support through a stressful military justice process:

I have received no support throughout the various responses and redress from my chain of command barring the obligatory [review] of his page of the MECRB [Medical Employment Classification Review Board]. His lack of understanding, empathy and comprehension of my situation was highlighted when he gave me a verbal back brief on [redacted] where he attempted to 'humanise' the MECRB delegate's thought process.⁴⁶⁵

456. While then Vice Admiral Johnston gave evidence of assurance measures in place that encouraged adherence to implementing policy and guidelines, he primarily referred to training, IGADF audits and complaints.⁴⁶⁶

457. This reinforces our argument in section 10.2: as it has no system Level 2 assurance system, Defence cannot monitor referral trends and confirm commanding officers consistently provide access to support to those who require it.

Reliance on command discretion

458. Reliance on command discretion to facilitate support depends on all leaders:

- being aware of policy
- understanding the behavioural indicators that members may be struggling with mental health
- creating an environment where the member feels comfortable to advise that they are struggling, and then
- facilitating referral.

459. Requesting support and assistance requires acknowledging a level of vulnerability that is likely to be a barrier for many members given mental health and help seeking has been stigmatised in Defence. It is challenging for any member to request support from the very person or people seeking to sanction them, especially for those who may not have a positive relationship with their commanding officer.⁴⁶⁷

460. In Chapter 15, Promoting health and wellbeing among ADF members, we discuss how a member will be discouraged from seeking help when they lack confidence their privacy and confidentiality will be respected and fear reprisals.

461. This is particularly of concern for members subject to administrative termination.

Lack of evaluation of mental health support

462. Defence advised us as part of our procedural fairness process that welfare and legal supports should be considered when assessing risks of harm, particularly if comparisons are proposed with civilian accountability and criminal justice proceedings.⁴⁶⁸

463. However, Defence has not, and cannot, evaluate the effectiveness of these supports. It cannot confirm these services meet the wellbeing needs of members subject to military justice proceedings. This is discussed in Chapter 29, Use of data and research by Defence and DVA, and Chapter 11, Governance and accountability in Defence.

464. Defence has confirmed that, since 1 January 2020, it has not evaluated the effectiveness of mental health support provided through health care, EAP, NewAccess, SeMPRO, DMFS or individual welfare boards for members subject to the military justice system.⁴⁶⁹
465. What evaluation has occurred, has been limited to the overall performance of the relevant contractor delivering the service or monitoring outputs delivered via memorandums of understanding, rather than evaluation of the experiences of recipients of the support or the realisation of outcomes that the program was established to achieve.⁴⁷⁰
466. We highlight in Chapter 11, Governance and accountability in Defence, that the absence of robust, evaluation-suitable data means that it is not possible to evaluate the effectiveness of Defence's mental health and wellbeing programs and suicide prevention activity.⁴⁷¹
467. The February 2023 *Protecting Lifetime Wellbeing* gap analysis found that:
- There are no initiatives which support the Organisational Justice Indicator, resulting in a potential gap in ensuring that member's values and ethics are not compromised, or if they have been compromised, support is provided.⁴⁷²
468. In the absence of assurance that these services are consistently provided and are effective, we do not accept Defence's proposition that these services are effective harm reduction controls in managing the inherent stressors within the military justice system.
469. We have highlighted the psychosocial risk factors for members engaging in the military justice system. Defence must evaluate whether its current support mechanisms effectively meet the needs of members exposed to administrative or disciplinary matters.

Recommendation 35: Determine whether support mechanisms for members involved with military justice processes are effective

Defence should evaluate the effectiveness of the key support mechanisms for those involved in military justice proceedings, including but not limited to:

- (a) support officers
- (b) individual welfare boards.

In its evaluation, Defence should consider members' experiences of the supports provided.

Support for those separated involuntarily for the reason ‘retention-not-in-service-interest’

470. In section 10.4, we highlight the link between those separated involuntarily for the reason ‘retention-not-in-service-interest’ and suicide. Defence must better prioritise legal and welfare supports for those members and ex-serving members.

471. Additional supports available for this cohort differ between services:

- Navy does not discuss administrative termination specifically, but describes the Personnel Support Unit, who can provide support to members facing ‘multifaceted personal issues’ when they are beyond the capacity of Navy’s ordinary military justice system. This includes transition support.
- Army points towards guidance booklets and reference material available to members on its Career Management website to help them understand the administrative termination process, and the commanding officers’ responsibility for member wellbeing.
- Air Force states that in the case of involuntary separation, members are ‘assigned an individual member support coordinator to provide support through the transition journey. The member support coordinator will conduct a post check-in once the member has successfully transitioned from service.’⁴⁷³

472. In June 2023, Defence updated its guidance on separation, mental health considerations and supports in Chapter 10 of the Military Personnel Policy Manual (MILPERSMAN). It acknowledged the need for mental health consideration and support for those subject to involuntary separation:

To account for sensitivities and mitigate unintended consequences of separation action, the member’s commander or chain of command should conduct a risk assessment for individual cases prior to delivering a separation decision. Relevant health staff, support organisations and chain of command should also be consulted, and a Support Officer should be appointed to check on the Defence member after the decision has been issued, to afford mental and physical wellbeing to the Defence member during the separation process.⁴⁷⁴

473. Colonel Gerrie Page, Director of Career Management and Support within Army, agreed there may be a tension where a commanding officer has initiated a termination process but is also responsible for that member’s wellbeing, ensuring their case is handled in a manner that is procedurally fair, and providing adequate welfare support.⁴⁷⁵

474. However, then Vice Admiral Johnston told us he thought the two roles were not mutually exclusive. He believes they ‘can coexist with each other and be performed satisfactorily within that arrangement’.⁴⁷⁶

475. This may be the case with certain commanding officers or with certain individual matters. However, this chapter has shown Defence lacks sufficient systemic mechanisms to ensure appropriate support is provided reliably and impartially.
476. Relying on the chain of command to identify the need for support and assist the member to access support is out of step with civilian criminal justice systems. In jurisdictions such as New South Wales and Queensland, referral to support services, or providing information about support services, is a minimum requirement at key stages in the process.⁴⁷⁷ In some jurisdictions, as is outlined later, referral is automatic and systemic, unless the individual opts out.
477. Serving members subject to a process that is proposing a serious sanction, such as administrative termination, should be automatically referred to services, with the ability to 'opt out' rather than relying on command discretion. A key part of it would be that the service initiates contact with the individual once it receives the referral.
478. This should also apply to both complainants and accused in unacceptable behaviour and sexual misconduct matters. As members accused of misconduct or a service offence are at a heightened risk of suicidality or suicide, the 'opt out' referral model could also be applied to this cohort. We discuss this in section 10.6.4.

Progress to date

479. In June 2023, the Chief of Defence Force signed a brief containing action items about mental health considerations including:
- Service Chiefs, the Chief of Joint Capabilities and the Chief of Joint Operations ensure that training for commanders includes command referral of members for psychological assessment and management advice
 - that the Military Personnel Policy Manual be updated to reflect that members being investigated for, or charged with, a serious offence be considered for an individual welfare board.⁴⁷⁸
480. However, Defence must look beyond administrative efforts to drive improvements and reduce risk factors that contribute to suicide and suicidality across the military justice system.
481. Wellbeing support is a critical safeguard in minimising harm. However, there is limited information available to enable us to determine if the current supports are effective in assisting members to navigate a complex and traumatic process. We have concerns about the current system of referring members to support services being so heavily reliant on the chain of command.

10.6.3 Automatic, 'opt out' referral to support services

482. We acknowledge that responsibility for member wellbeing rests with command because it needs to be transferable to deployment.⁴⁷⁹ However, there needs to be a more systemic process for members to access support that addresses some of the help-seeking barriers. It must also address the unrealistic requirement for members to seek help from the very people who may be taking adverse action against them.
483. There are opportunities for Defence to explore and consider practices that have evolved in the civilian justice jurisdictions, aimed at improving safeguards, and how they may be applied in a military justice context.
484. Defence argued in its procedural fairness responses that the military justice system is uniquely different to the civilian justice system due to the focus on maintaining service discipline, the centrality of command, the nature of service offences, the procedures used for summary proceedings and disciplinary infringements, and the punishments available.⁴⁸⁰
485. Defence stated that the significant welfare and legal support available to participants in military justice proceedings also differentiates it from civilian justice systems.⁴⁸¹
486. While we acknowledge the differences between the two, there are similarities in the inherent stressors for any person involved in an adversarial process, whether that be in the civilian system, or in the military justice disciplinary or administrative systems. Therefore, there are opportunities for Defence to consider and learn from civilian justice jurisdictions when considering trauma-informed practices, and improving access to support services.
487. We also highlighted in the previous section that Defence is unable to provide assurance that the current wellbeing and legal supports are effective. We have heard via testimony and submissions of instances where people have struggled to access support in the military justice system, or where little support has been provided.⁴⁸²
488. Automatic 'opt out' referral models to support services can be effective at removing barriers to accessing support and improving wellbeing outcomes throughout the justice process.⁴⁸³ In the civilian context, some of these models focus on victims of crime. Others are broader, for example alcohol and drug referrals, and can also apply to accused persons.⁴⁸⁴
489. A European Union handbook for implementation of legislation and best practice for victims of crime reviewed various models across those countries. It noted referrals are one of the single greatest barriers to victims' ability to access support services.⁴⁸⁵
490. The handbook suggests the vast majority of victims would like to receive an offer of support without having to formally request it. It notes that good practice models for accessing support are automatic, facilitated, 'opt out' referral models.⁴⁸⁶

491. These are models where the agencies (such as the police or courts) advise the victim they will pass on their details to the support service, unless the victim would prefer they do not.⁴⁸⁷ The victim is provided with the opportunity to 'opt out' of the referral, which is important from a privacy and consent point of view.⁴⁸⁸ If the victim does not 'opt out,' the agency hands their details to the relevant support service which initiates contact with the victim through their preferred method (such as phone or email).⁴⁸⁹
492. These models are considered effective in assisting to overcome some of the help-seeking barriers that exist within vulnerable cohorts.⁴⁹⁰
493. New South Wales has a similar process in family violence matters, where the relevant justice agency (police or courts) undertake automatic referral to support services with opt out provisions depending on the threat assessment.⁴⁹¹
494. The Victoria Police e-referral system allows police, with a victim's consent, to send an electronic referral to the Victims of Crime Helpline.⁴⁹² For family violence matters, victims are referred to a family violence service, and children are referred either to the Department of Health and Human Service's child protection service or a child and family information, referral and support team.⁴⁹³
495. Referrals are consent based for non-crisis incidents and categories include victim support, financial counselling, and alcohol and drug addiction.⁴⁹⁴ The referral to support is offered in every case by the relevant agency and unless the person 'opts out,' is facilitated by that agency via an email or system notification to the relevant support service.
496. Automatic opt out referral models would likely improve members' access to wellbeing support services through the military justice process by:
- removing help-seeking barriers for members, noting those needing support may be feeling highly vulnerable especially where the chain of command is initiating adverse action against them
 - removing the current, heavy reliance on command to exercise discretion, that requires all leaders to have the qualities of emotional intelligence, empathy, knowledge and understanding of behavioural indicators that a member may be in distress
 - overcoming the cultural stigma, whether perceived or real, that asking for support is a weakness and members will be punished for doing so. If the referral requirement is automatic, then this assists in removing the stigma, and the perception.
497. An automatic, opt out referral model will have resource implications for the Australian Government. Demand for services will likely increase, privacy considerations will require assessment (although these have been addressed and overcome in civilian jurisdictions) and systems to support automatic referral require scoping (noting some jurisdictions facilitate this via email forms). These all may best be resolved by first undertaking a pilot.

498. In civil jurisdictions, the states and territories often fund dedicated support services with case workers who are the individual's primary contact, and those case workers link the individual in with the different supports that they need across various service systems. How this may work within Defence requires further consideration.

Recommendation 36: Trial a model outside the chain of command for supporting members involved in military justice processes

The Australian Defence Force (ADF) should fund and pilot a model for automatic, opt-out referral to both legal and welfare support services for members engaged in certain military justice processes that is separate from the chain of command (for example, the Workplace Behaviour Adviser Network, the Sexual Misconduct Prevention and Response Office, and the Employee Assistance Program).

In developing the pilot, the ADF should:

- (a) consider the role of individual welfare boards in the process
- (b) make it clear that once the referral is received, the relevant service would be responsible for initiating contact
- (c) consider thresholds for referral, and focus on increasing support for members exposed to factors known to contribute to higher risk of psychosocial harm, suicide and suicidality for example:
 - (i) those involved (both as victims and accused) in unacceptable behaviour complaints, sexual misconduct incidents, and disciplinary proceedings for offences under the *Defence Force Discipline Act 1982* (Cth)
 - (ii) those who are being considered for administrative termination.

The ADF should evaluate the pilot at its conclusion to assess the demand impacts and benefits in order to inform the decision for a broader roll-out.

10.6.4 Minimum standards for complainants and other participants in the military justice process

499. Defence should develop minimum standards as a statement of intent for all participants in the military justice process. They will help establish stronger accountability for those initiating or investigating to ensure more trauma-informed practice.

500. Victims' charters, or codes of conduct, set out minimum standards a victim can expect when they engage with a justice process. As the Victorian Victims of Crime Commissioner said:

One of the objectives of the Victims' Charter is to help reduce the likelihood of secondary victimisation by the criminal justice system. Victims have told the Victims of Crime Commissioner that the justice system often adds to the trauma they've already experienced and some state clearly that the trauma caused by the system is as worse or worse than the crime they experienced. To the maximum extent possible, the justice and service system should adopt a trauma-informed approach, uphold victims' rights and entitlements and ensure a fair process for the accused.

A trauma-informed justice system does not aim to undermine notions of procedural fairness for the accused. Instead, a trauma-informed justice system accommodates, and makes space for, the ways in which trauma may manifest and impact on a person's ability to participate in processes.⁴⁹⁵

501. Victoria, Queensland, South Australia, and Western Australia have a Victims' Charter enshrined in legislation.⁴⁹⁶ The Northern Territory, New South Wales, Tasmania and Australian Capital Territory have a Victims' Charter as a statement of policy intent.⁴⁹⁷ Such charters also operate in the United Kingdom, Ireland and several European Union countries.

502. Common principles include a commitment by justice agencies and support services to:

- treat victims of crime with dignity, respect and courtesy
- provide victims with information about support services available to them, or facilitate the referral depending on the jurisdiction
- communicate at key stages or intervals of the process, including outcomes
- ensure victims of crime have the information they need to engage with the justice system, including about how the justice system works.⁴⁹⁸

503. The concept of minimum standards for those subject to justice proceedings does not apply solely to victims of crime. Australia is party to international human rights treaties, which include minimum guarantees in criminal proceedings.⁴⁹⁹ Article 14 of the International Covenant on Civil and Political Rights enshrines the right to a fair trial and the right to the presumption of innocence. It contains minimum guarantees including, but not limited to, minimising delays, providing information about allegations in writing, and giving the opportunity for independent review by a higher court.⁵⁰⁰

504. This chapter has outlined members' experiences about:

- not being treated with courtesy, dignity or respect
- inconsistent referrals and access to support services
- confusing military justice processes
- not being kept informed of the progress of their case, or of the outcome.

505. The Chief of Navy highlighted the importance of the principle of treating people with dignity and respect, and making a commitment to do so:

The way I approach the issue of culture in Navy is that I talk about setting an environment in which our people want to get out of bed and come to work because of what we do and how we do it. It's about treating people with dignity and respect. And for me – if we focus on creating that environment and we treat all people at all levels with dignity and respect, regardless whether they are subject to a discipline outcome, especially when they are feeling vulnerable, then I think we will set the culture that we need in order to see the Royal Australian Navy thrive.⁵⁰¹

506. Defence should develop and communicate a simple statement of minimum standards for the people who interact with the military justice system. These standards should be easily accessible for witnesses, complainants and respondents and for members who are subject to administrative inquiries or disciplinary processes for other matters.

Recommendation 37: Develop a charter of minimum standards for all members involved in military justice processes

The Australian Defence Force (ADF) should develop a charter of minimum standards for all members involved with or subject to disciplinary processes, or involved in matters handled by the Inspector-General of the ADF. It should include commitments to:

- (a) treating members with courtesy, compassion, dignity and respect, and consideration of their welfare needs
- (b) providing members with information that is clear and understandable about:
 - (i) the relevant military justice processes
 - (ii) the legal, welfare and victim-support services available to them
- (c) referring members to relevant support services
- (d) providing updates at key stages of the process, including explaining the outcomes at its conclusion
- (e) giving victims of unacceptable behaviour the opportunity to provide a victim impact statement to inform sentencing, where the accused has been found guilty.

The charter should also contain defined roles and responsibilities for meeting the minimum standards.

The charter should be publicly available and members may refer to these minimum standards via the existing appeals and complaints processes where they feel these standards have not been upheld.

10.7 Barriers to change

507. As outlined throughout this chapter, Defence continues to rely heavily on policy changes to address issues within the military justice system. Yet these actions will be ineffective if policy is complied with inconsistently.
508. This has been highlighted through the analysis of IGADF audits, along with papers to MJSG concerning inconsistent application of the administrative system.⁵⁰²
509. The 2022 analysis of IGADF Military Justice Performance Audit Reports identified themes regarding inconsistent application of policy and processes, especially in the administrative system when compared to the disciplinary system:

This may indicate a lack of performance standards and efficiency measures relating to the administrative system. The administrative system inherently consists of principles based decision-making, as distinct from the disciplinary system which requires compliance with set powers and rules, adherence to specific timeframes and the use of set forms.⁵⁰³

510. A paper to the MJSG on 6 September 2022 flagged concerns with consistency in application where enterprise policy exists.⁵⁰⁴ We also note the Commonwealth Ombudsman's statement in 2023 that they could not be satisfied 'that there is consistency in approach across the services and the APS.'⁵⁰⁵
511. The 2011 Report of the Australian Defence Force Personal Conduct Review highlighted the ineffectiveness of relying on administrative changes in driving change:

The ADF's tendency in reacting to organisational failures and poor behaviour is to focus on changes to administrative procedures and process. This is despite the fact that many reports allude to the need for cultural change. The usual response has been essentially procedural, resulting in a table of recommendations each of which is then individually implemented over time. This, however, is not a reliable strategy for cultural change, with the combined effect of individual recommendations often falling short of the overall intent. It follows that, while the ADF must be heedful of the need to improve in specific areas, it must also take a wider, strategic, and systems-based view for improvement.

512. During Hearing Block 12, then Vice Admiral Johnston acknowledged that there has been a lot of activity around planning but limited execution or progression due to capacity issues in the small group of people who are responsible for a variety of outcomes.⁵⁰⁶

513. Minutes from the November 2022 Legal Justice Forum also highlighted challenges in gaining command buy in when driving change:

DGMLB [Director-General of the military law branch] noted two challenges in the military justice space are achieving command buy-in in to military justice matters, as well as reminding command that it is command, and not Defence Legal, who are responsible for driving policy matters. CAPT Jones (DMADLaw) noted that in the scheme of things, it is likely that Command assesses that the military justice system on balance works well and therefore presents low relative risk compared to other matters that command is dealing with.⁵⁰⁷

514. Vice Admiral Johnston further highlighted the complexities in driving change in a diverse and dispersed workforce:

So the breadth of roles that we perform in delivering the security for our nation make it, in aggregate, a complex organisation.⁵⁰⁸

515. Fundamental to overcoming the issues highlighted in this chapter will be the establishment of a home for military justice, that includes bringing all elements of Level 2 assurance under one roof.
516. Level 2 assurance must be strengthened throughout the system so that respective governance committees can monitor issues and trends and generate trigger points for further curiosity. This will also enable monitoring of strategies targeted at issues to assess their effectiveness, not just implementation. Establishing these mechanisms must be prioritised.

10.8 Conclusion

517. As with any justice system there are stressors inherent in the military justice one that may impact a member's wellbeing. This impact may be multiplied if a member has become involved in the system in the first place because a decline in their mental health has caused changes in their behaviour or performance.
518. It can be particularly challenging for command to respond in a way that addresses the behaviour, preserves the overall discipline of the unit and supports both the accused and potential victims.
519. We recognise Defence's efforts to date, but have demonstrated throughout this chapter there is room for significant progress.
520. We are especially concerned about the slow pace of reform to the military justice system. Delays have real consequences, and reducing those can save lives.

521. We have identified that the increasing use of administrative justice mechanisms to manage behaviour is a source of risk. That is because it relies on command discretion, which has led to inconsistent application of procedural fairness. There is significantly less opportunity for effective oversight.
522. We have shown these risks to be a symptom of weak governance, but we are optimistic that the ADF can actively address this.
523. Defence does not currently have sufficient mechanisms to understand the scale and scope of everything that occurs under the umbrella of the military justice system. It currently has some governance bodies, such as the MJSG and the Military Justice Legal Forum, but they are limited by the channels that feed into them.
524. Discrete acts like amending a policy or guidance manual are insufficient to create the systems change needed to reduce the disturbingly high rates of suicide of serving and ex-serving members.

10.8.1 A home for military justice

525. Specifically, we want to see a 'home' for military justice where:
- comprehensive, consistently entered data can be analysed to inform policy and operational reform
 - technical aspects of military justice can be linked to mental health and suicide data to better understand the psychosocial risks associated with military justice
 - the three levels of assurance are governed by clear frameworks which are monitored and evaluated
 - education and support underpins all military justice action to ensure procedural fairness and the ongoing wellbeing of all members involved.
526. This visibility is absolutely crucial for identifying, managing and tracking risks. This in turn facilitates the design and provision of appropriate, trauma-informed legal and welfare supports and preventative measures.

Endnotes

- 1 Appendix I, Comparative rates of suicide – ex-serving ADF members.
- 2 Exhibit 35-02.026, Hearing Block 5, Department of Defence, Response to Notice to Give, NTG-DEF-005, DEF.9999.0001.0136 at 0137 [1–3].
- 3 Exhibit 86-03.051, Hearing Block 12, Defence submission on Military Justice, 28 February 2024, DEF.0000.0001.0004 at 0009 [20].
- 4 Department of Defence, ‘Values and behaviours’, webpage, www.defence.gov.au/about/who-we-are/values-behaviours, viewed March 2023.
- 5 Exhibit 86-03.051, Hearing Block 12, Defence submission on Military Justice 28 February 2024, DEF.0000.0001.0004 at 0006 [5]–0009 [19].
- 6 Exhibit 86-03.051, Hearing Block 12, Defence submission on Military Justice 28 February 2024, DEF.0000.0001.0004 at 0008 [12, 11].
- 7 Exhibit 86-03.051, Hearing Block 12, Defence submission on Military Justice 28 February 2024, DEF.0000.0001.0004 at 0008 [11].
- 8 Exhibit 86-03.051, Hearing Block 12, Defence submission on Military Justice 28 February 2024, DEF.0000.0001.0004 at 0008 [15, 16].
- 9 Transcript, David Johnston, Hearing Block 12, 4 March 2024, p 86-8472 [35].
- 10 Transcript, David Johnston, Hearing Block 12, 4 March 2024, p 86-8472 [15].
- 11 Exhibit 86-03.051, Hearing Block 12, Defence submission on Military Justice 28 February 2024, DEF.0000.0001.0004 at 0008 [17].
- 12 Australian Commission on Safety and Quality in Healthcare, *Independent Review of Past Australian Defence Force and Veteran Suicides: Qualitative analysis of coronial and Defence documents*, November 2021, p 100 (Exhibit 18-02.010, Hearing Block 3, ACS.0001.0001.2552).
- 13 Exhibit 86-03.051, Hearing Block 12, Defence submission on Military Justice 28 February 2024, DEF.0000.0001.0004 at 0010–0011 [Table 1].
- 14 Exhibit 101-03.027, Hearing Block 12, Inspector General of the Australian Defence Force: Directorate of Military justice Performance Review Standard Operating Procedures 05 May 2023, IGD.0017.0001.0001 at 0008 [1.10].
- 15 Exhibit 35-02.026, Hearing Block 5, Department of Defence, Response to Notice to Give, NTG-DEF-005, DEF.9999.0001.0136 at 0145 [36] –0146 [43].
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- 17 *Defence Force Discipline Act 1982* (Cth) ss 3A, 9B, 9D.
- 18 Exhibit 35-02.026, Hearing Block 5, Department of Defence, Response to Notice to Give, NTG-DEF-005, DEF.9999.0001.0136 at 0145 [39]; Pauline Collins, Submission, ANON-Z1E7-QWCC-N.
- 19 Exhibit 35-02.026, Hearing Block 5, Department of Defence, Response to Notice to Give, NTG-DEF-005, DEF.9999.0001.0136 at 0151 [57].
- 20 Exhibit 35-02.026, Hearing Block 5, Department of Defence, Response to Notice to Give, NTG-DEF-005, DEF.9999.0001.0136 at 0151 [57].
- 21 Exhibit 35-02.026, Hearing Block 5, Department of Defence, Response to Notice to Give, NTG-DEF-005, DEF.9999.0001.0136 at 0151 [60].
- 22 Exhibit 35-02.026, Hearing Block 5, Department of Defence, Response to Notice to Give, NTG-DEF-005, DEF.9999.0001.0136 at 0152 [63].
- 23 Exhibit 35-02.026, Hearing Block 5, Department of Defence, Response to Notice to Give, NTG-DEF-005, DEF.9999.0001.0136 at 0153 [63–64].
- 24 Justice Logan, *Administrative Discharge in lieu of Military Disciplinary Proceedings – Supportive or Subversive of a Military Justice System?*, paper, Federal Court of Australia, 16 November 2018, (Exhibit 84-03.067, Hearing Block 11, DVS.0011.0001.0160); Exhibit 86-03.051, Hearing Block 12, Defence submission on Military Justice, 28 February 2024, DEF.0000.0001.0004 at .0017
- 25 Exhibit 35-02.027, Hearing Block 5, Department of Defence, Response to Notice to Give, NTG-DEF-005, DEF.9999.0001.0181 at 0216 [159].
- 26 Exhibit F-03.001, Summary Discipline Manual, DEF.1005.0001.1639 at 1660 [1.21] and 1745 [6.62] Justice Logan, *Administrative Discharge in lieu of Military Disciplinary proceedings – Supportive or Subversive of a Military Justice System?*, paper, Federal Court of Australia, 16 November 2018, p 10 (Exhibit 84-03.067, Hearing Block 11, DVS.0011.0001.0160).

- 27 Exhibit 35-02.027, Hearing Block 5, Department of Defence, Response to Notice to Give, NTG-DEF-005, DEF.9999.0001.0181 at 0217 [160].
- 28 Exhibit 35-02.027, Hearing Block 5, Department of Defence, Response to Notice to Give, NTG-DEF-005, DEF.9999.0001.0181 at 0217 [160].
- 29 Exhibit 78-02.005, Hearing Block 11, Commanders' Guide to Discipline, 2nd Edition, September 2020, DEF.1024.0001.3876 at 3882 [1.6].
- 30 Exhibit 35-02.026, Hearing Block 5, Department of Defence, Response to Notice to Give, NTG-DEF-005, DEF.9999.0001.0136 at 0146 [44].
- 31 Exhibit 35-02.026, Hearing Block 5, Department of Defence, Response to Notice to Give, NTG-DEF-005, DEF.9999.0001.0136 at 0017 [75].
- 32 Exhibit 75-02.012, Hearing Block 10, Department of Defence, Military Personnel Policy Manual, DEF.1166.0005.0014 at 0679 [2.15].
- 33 Exhibit 35-02.026, Hearing Block 5, Department of Defence, Response to Notice to Give, NTG-DEF-005, DEF.9999.0001.0136 at 0150 [53].
- 34 Exhibit 35-02.026, Hearing Block 5, Department of Defence, Response to Notice to Give, NTG-DEF-005, DEF.9999.0001.0136 at 0146 [43].
- 35 Exhibit 35-02.026, Hearing Block 5, Department of Defence, Response to Notice to Give, NTG-DEF-005, DEF.9999.0001.0136 at 0020 [76].
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- 37 Exhibit 35-02.026, Hearing Block 5, Department of Defence, Response to Notice to Give, NTG-DEF-005, DEF.9999.0001.0136 at 0165 [114].
- 38 Exhibit 78-02.001, Hearing Block 11, Department of Defence, Response to Notice to Give, NTG-DEF-016, DEF.9999.0103.0123 at 0159 [102]; *Defence Regulation 2016* (Cth) s 6(2).
- 39 Exhibit 35-02.026, Hearing Block 5, Department of Defence, Response to Notice to Give, NTG-DEF-005, DEF.9999.0001.0136 at 0146 [43].
- 40 Exhibit 35-02.027, Hearing Block 5, Department of Defence, Response to NTG-DEF-005 DEF.9999.0001.0181 at 0186 at [21].
- 41 Exhibit 35-02.026, Hearing Block 5, Department of Defence, Response to Notice to Give, NTG-DEF-005, DEF.9999.0001.0136 at 0146 [44].
- 42 Name withheld, Submission, ANON-Z1E7-QEEE-7, p [3]; Exhibit 64-01.022, Hearing Block 9, Analysis of IGADF Military justice Performance Audit Reports 01 Jan 21–30 Sep 22, DEF.1186.0001.0001 at 0036-0037; Exhibit 79-02.005 Hearing Block 11, Department of Defence, Response to Notice to Give, NTG-IGD-009, IGD.9999.0005.0001 at 0006 [4]; Exhibit 35-02.026, Hearing Block 5, Department of Defence, Response to Notice to Give, NTG-DEF-005, DEF.9999.0001.0136 at 0139 [25]–0144 [35].
- 43 *Defence Force Discipline Act 1982* (Cth); *Criminal Code Act 1995* (Cth); *Defence, Legislation Amendment (Discipline Reform) Bill 2021*; Defence (Inquiry) Regulations 2018; Exhibit 82-03.036, Hearing Block 11, Military Personal Policy Manual, 2017 ACA.1001.0005.2002; Exhibit G-01.005, Defence Instruction Administrative Policy, ACA.1001.0005.1725; Exhibit D-01.003, Incident Reporting and Management Manual, DEF.0011.0001.1459; Exhibit 101-03.005, Hearing Block 12, Defence Security Principles Framework, TAL.1001.0001.4150; Exhibit F-03.002, Good Decision-Making in Defence: A Guide for Decision-Makers and Those Who Brief Them, DEF.1005.0001.2294; Exhibit H-01.001, Defence Force Discipline Act Law Manual 2020, DEF.1005.0003.0281; Exhibit F-03.010, Director of Military Prosecutions Prosecution Policy, DEF.1024.0001.4031; Exhibit F-03.001, Summary Discipline Manual, DEF.1005.0001.1639; Exhibit 01-03.099, In Depth Inquiry 2, Complaints and Alternative Manual, Chapter 3, DEF.1096.0001.0985; IDI Exhibit 01-03.091, In Depth Inquiry 3, Administrative Inquiries Manual, Third Edition, DEF.1052.0003.0592
- 44 Exhibit PP-01.001, Defence response to Commonwealth Ombudsman draft report of own motion inquiry into Defence effectiveness, DEF.1330.0004.0001 at 0059.
- 45 Complaints and Alternative Resolutions Manual Chapter 4, DEF.1387.0001.0001 at 0010 [4.2.0.6]
- 46 M Clemente and D Padilla-Racero, 'The effects of the justice system on mental health', *Psychiatry Psychology and Law*, vol 27, 5, 2020, p 865–879.
- 47 The VCDF no longer holds the position of accountable officer for the military justice system. That position is now held by Chief of Personnel (current Lt General Fox); Transcript, David Johnston, Hearing Block 12, 4 March 2024, p 86-8475 [0–5].
- 48 Transcript, David Johnston, Hearing Block 12, 4 March 2024, p 86-8475 [10–20].
- 49 Transcript, Angus Campbell, , Hearing Block 12, 28 March 2024, p 101-10295 [18–35].

50 Transcript, Angus Campbell, Hearing Block 12, 28 March 2024, p 101-10295 [20–35];
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51 Australian Commission on Safety and Quality in Healthcare, *Independent Review of Past
 Australian Defence Force and Veteran Suicides: Qualitative analysis of coronial and Defence
 documents*, November 2021, p 83 (Exhibit 18-02.010, Hearing Block 3, ACS.0001.0001.2552).

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 documents*, November 2021, p 84 (Exhibit 18-02.010, Hearing Block 3, ACS.0001.0001.2552).

53 Appendix I, Comparative rates of suicide – ex-serving ADF members.

54 Appendix H, Comparative rates of suicide – current serving ADF members

55 Appendix I, Comparative rates of suicide – ex-serving ADF members.

56 Appendix I, Comparative rates of suicide – ex-serving ADF members; Exhibit 89-02.027,
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57 Appendix I, Comparative rates of suicide – ex-serving ADF members; Exhibit 89-02.027,
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 Attachment A, AHW.9999.0005.0001 Table 8.

58 Exhibit 89-02.027, Hearing Block 12, Australian Institute of Health and Welfare response to
 NTG-AHW-008, Attachment A, AHW.9999.0005.0001 Table 5.

59 Transcript, General Angus Campbell, Chief of Defence Force, Hearing Block 12, 28 March
 2024 at 101-10304 [25-30].

60 PFLR-18.1 (Military Justice, Commonwealth Response), PFL.0007.0002.0026 at 0026

61 Exhibit F-03.006, Phoenix Australia, *Wellness Action Through Checking Health, WATCH
 Project Report*, 2022, p 22 (Exhibit F-03.006, DEF.1155.0003.0542).

62 Exhibit F-03.006, Phoenix Australia, *Wellness Action Through Checking Health, WATCH
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 70].

65 Transcript, Patrick Keane, Hearing Block 11, 7 September 2023, p 84-8225 [32–47].

66 Transcript, Kahlil Fegan, Hearing Block 5, 20 June 2022, p 32-3053 [1–28].

67 Transcript, Peter Francis, Hearing Block 11, 30 August 2023, p 78-7597 [37] – 78-7598 [6].

68 Transcript, Kahlil Fegan, Hearing Block 5, 20 June 2022, p 32-3053 [10-15].

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73 Transcript, David Johnston, Hearing Block 12, 4 March 2024 p 86-8474 [40–45].

74 Exhibit 86-03.019, Hearing Block 12, VCDF to CPERS Handover Takeover Pack Military
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75 Exhibit G-01.005, Defence Instruction: Administrative Policy, ACA.1001.0005.1725 at 1735.

76 Transcript, David Johnston, Hearing Block 12, 4 March 2024, p 86-8453 [23-28].

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 IGD.0007.0006.0094; Exhibit 84-01.036, Hearing Block 11, Military justice Steering Group,
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Part 4

Governance and accountability

11 Governance and accountability in Defence

Summary

Governance is the system of control and oversight that guides decision-making towards delivering an organisation's objectives. Good governance involves:

- clear accountability at all levels of the organisation
- strategic and corporate planning that sets the priorities and embeds them in every part of the organisation
- a clear and transparent approach to risk management
- evaluating performance and the outcomes of activities
- continuous improvement.

In an organisation as large, diverse and decentralised as the Australian Defence Force (ADF), good governance is crucially important. Strengthening governance and accountability in Defence is essential for driving the kinds of reform that will reduce rates of defence and veteran suicide and suicidality.

Suicide and suicidality are complex, emergent phenomena. This means that rather than being caused by one or two factors, they emerge from the dynamics of the system as a whole. Issues of governance and accountability, which may seem remote from the psychological stressors more commonly associated with suicide risk, shape the dynamics of the whole organisation. They are actually not remote at all.

This chapter describes Defence structures of governance and accountability and the practices associated with them. Our inquiry has found limitations within Defence governance functions that reduce the organisation's ability to change the dynamics that give rise to suicide and suicidality among serving and ex-serving members.

- The three-tiered structure of Defence's enterprise committees lacks clarity and has diluted the responsibility and accountability of senior leaders for addressing risk factors for suicide and suicidality.
- The ADF has only recently acknowledged service as a risk factor for suicide and suicidality. Risk factors related to service are not fully recognised at the enterprise level of risk management, nor are they adequately addressed in strategy documents related to employee health and wellbeing.
- Access to quality, timely, enterprise-wide data has been lacking. This means it has not been possible to analyse trends related to performance, capability building and risk in the Defence environment, let alone to understand the systemic issues behind such trends.

- While Defence has implemented suicide-prevention initiatives, the existence of programs and research activities alone does not give rise to a strong organisational understanding of stressors and risks associated with service. The outcomes of these efforts need to be evaluated and measured if they are to be effective.
- Defence has tended to monitor the implementation of the recommendations of previous reviews based on whether the activity has been completed, rather than evaluating whether the implementation was effective.¹

Defence has informed us of a range of initiatives underway to improve data collection and sharing, research, accountability, performance measurement and project management. While we welcome these reforms, we are not able to comment on their effectiveness.

In this chapter, we make four recommendations aimed at:

- (1) improving the accountability of leaders responsible for delivering outcomes
- (2) identifying and addressing obstacles to reporting and governance compliance for busy managers
- (3) ensuring mental health and wellbeing strategies consider and mitigate in-service risks
- (4) improving Defence project management capability to effectively implement reforms.

The recommendations are framed to identify the specific steps required to ensure they are effectively implemented and monitored. The stubbornly high rate of suicide among serving and ex-serving ADF members serves as a tragic reminder of the importance of accountability, continuous improvement, learning from past mistakes, and monitoring and adjusting activities to ensure they have the desired effect.

11.1 Introduction

1. The themes of Defence governance and accountability are relevant to our terms of reference, which require us to ‘inquire into ... systemic issues and common themes and [make] a systemic analysis of the contributing risk factors relevant to defence and veteran death by suicide’.²
2. An inquiry into systemic issues has to begin by looking at Defence systems of governance and identifying how the organisation manages the central governance functions of accountability, strategic and corporate planning, risk management, performance management and continuous improvement.
3. The management of these functions is linked indirectly and directly to organisational dynamics underpinning suicide risk. The following examples seek to describe some of those dynamics.
 - A strong culture of accountability – and clear mechanisms of accountability at all levels – make an organisation trustworthy and able to learn from its mistakes. Members of any organisation ‘need to know that their leaders have their back and will step up and take accountability’.³ Members need to know that when someone does something wrong, they will be held accountable for their actions, and when something goes wrong, it will be fixed. When this does not occur, it can lead to institutional betrayal, which elevates suicide risk. When mechanisms of accountability are lacking, it is very difficult for reform programs to get traction, meaning organisational culture does not change and the same problems occur again and again.
 - Strategic and corporate planning are how an organisation sets its vision and priorities at the highest level. Done well, these priorities filter into every aspect of organisational life, and the success of their translation into day-to-day operations is carefully observed and monitored. This means implementation plans can be adapted if they are not working. When suicide prevention and the health and wellbeing of members are not among the highest priorities, it is this that flows into all areas of the organisation – and it shows.
 - Risk management is the mechanism by which organisational risks and hazards (including psychosocial hazards) are identified and eliminated – or at least mitigated. If a hazard or risk cannot be mitigated, as can be the case in the Defence environment, good risk management would entail considering:
 - how exposure could be minimised
 - how people’s susceptibility could be reduced
 - how protective factors could be strengthened and made more accessible.

We have not seen the risk factors that contribute to suicide and suicidality adequately reflected in Defence's enterprise risk management. This means opportunities to remove or reduce harm have not been fully realised and it is the members who bear the consequences of this oversight.

- Performance management is how an organisation's priorities can be embedded in the performance standards by which its leaders are scrutinised. When an organisation prioritises the health and wellbeing of its members, it will assess its leaders on whether their people are healthy and well. The outcomes of projects and initiatives also need to be carefully monitored so the organisation can determine whether they worked, and if not, why not.
 - When an organisation prioritises continuous improvement, it becomes 'data hungry', because collecting, sharing, analysing and using data is vitally important if leaders at all levels of an organisation are to know what is going on at ground level. Data is not only obtained by measuring and counting things but also by truly listening to people, caring about their experiences, and listening to their views, needs and suggestions. If an organisation believes it 'cannot afford' to listen to its people, and has inadequate data systems and low data-literacy where it counts, continuous improvement in member wellbeing will remain unattainable.
 - Effective data collection and analysis is crucial to robust risk identification, intervention, management and monitoring. Chapter 29, Use of data and research by Defence and DVA, also discusses the limitations in Defence's current process for reporting suicidality and deaths by suicide. The limited availability of useful data, identified in that chapter, significantly reduces the efficacy of Defence governance systems.
4. Throughout the rest of this chapter, we will unpack these concepts and look at how Defence governance systems, structures and processes both support and inhibit the proper functioning of these mechanisms, as they relate to suicide prevention and the health and wellbeing of serving members.
5. As we discuss throughout this report, numerous internal and external inquiries have investigated serving and ex-serving members' suicide and suicidality. They repeat the same themes, including that:
- there is unclear accountability for mental health and wellbeing in the ADF
 - issues of stigma around perceived weakness and help-seeking are entrenched in military culture
 - the data that is collected and collated is not sufficient as an evidence base for understanding trends related to suicide and suicidality
 - the ADF tends to 'tick off' that an activity has been done, or a recommendation implemented, rather than measuring its effectiveness or determining whether it has had the desired outcome
 - Defence as a whole needs to have a stronger focus on continuous improvement.

6. Throughout this report, we highlight that a military career has distinct phases and transition points, each of which can expose serving and ex-serving members to different risks. These risks can singly or cumulatively increase the risk of suicide and suicidality among these cohorts.
7. We have observed that in-service risk factors are not adequately reflected in Defence's risk management or mental health and wellbeing strategy development, which has instead tended to focus on transition. This is not entirely surprising given we have only recently heard senior ADF leaders acknowledge that service is not always protective. We also found that when certain risk factors had been identified, the effectiveness of interventions to address them was not consistently assessed.
8. Though suicide may not be predictable for every individual, it must be viewed as preventable. Identifying and mitigating known risk factors is a crucial first step in suicide prevention.
9. As highlighted by then Chief of the Defence Force, General Angus Campbell AO DSC:

I think it is an extremely complex challenge, problem, and there is a great deal of effort going on but more is needed. We have to keep working at it. And so, where issues of culture are at play, these things can take a number of years and I realise, Counsel, that we don't have a number of years. It is a very, very serious issue and these are our people and the numbers of the different factors that are indicating here are very, very concerning.⁴
10. We acknowledge the work of previous reviews into suicide and suicidality in the Defence community. The stubbornly high rate of suicide among Defence members and veterans serves as a tragic reminder of the importance of learning from previous implementation efforts.
11. The consequences of Defence's inability to effectively implement recommendations of past reviews are borne by serving and ex-serving members. This cannot continue if Defence is to have any reasonable expectation of improving health and wellbeing outcomes for Defence personnel. Our recommendations aim to support Defence to navigate these difficult issues and improve on its existing governance and accountability frameworks and systems.
12. The November 2023 *Final Report to the Deputy Prime Minister and Minister for Defence* by the Afghanistan Inquiry Implementation Oversight Panel is important to our inquiry.⁵ Although the report does not focus on suicide and suicidality, it identifies limitations in Defence's leadership, governance and accountability structures that reflect our findings. It highlights how shortfalls in governance and accountability have contributed to organisational limitations in effectively addressing critical issues.

11.2 Explaining governance and accountability

13. In this section, we explain the core organisational functions of governance and accountability. We explore what constitutes *good* governance and accountability, and look at how they support evidenced-based decision-making, strategy development and reform.
14. We recognise that Defence's organisational structure is distinct from that of other public sector entities (outlined in section 11.3). For this reason, governance and accountability models that are appropriate to the unique purpose and structure of the ADF need to be applied.

11.2.1 What is good governance?

15. Defence describes governance as all arrangements intended to align its strategy, processes and resources with broader government direction.⁶ This aligns with other conceptual frameworks used in the public sector.
16. We draw on a number of Audit Insights reports from the Australian National Audit Office (ANAO), the Australian Government entity responsible for overseeing the performance of Commonwealth departments and agencies.
17. The ANAO distinguishes between 'governance' and 'management', describing governance as 'the systems and processes ... that shape, enable and oversee the management of an organisation'.⁷
18. Management, on the other hand, is 'concerned with doing, such as coordinating and managing the day-to-day operations of the entity's business'.⁸
19. In its Audit Insights Report 'Rapid Implementation of Australian Government Initiatives' the ANAO also states:

Effective governance arrangements will incorporate a clear reporting framework that provides for accurate, reliable and relevant information to key stakeholders to assist decision making on strategic priorities and the timely management of risks and issues. Entity governance should maintain focus on business as usual activities as well as new or expanded initiatives, and be alive to the proper use of resources.⁹

20. We draw on the ANAO's insights and definitions to consider how effective Defence's governance framework has been at identifying and responding to risks that contribute to serving and ex-serving member suicide and suicidality.

11.2.2 What does it mean for an organisation to have ‘good accountability’?

21. Accountability is defined as liable to be called to account; responsible (to a person, for an act);¹⁰ and ‘to give account of performance to someone entitled to demand that account’.¹¹ Whereas responsibility is task focused, accountability is results focused.
22. Accountability is linked to performance and is therefore underpinned by the data and record-keeping that allow performance to be determined. As stated by the ANAO:

Performance statements are intended to be the key accountability document to inform an assessment by the Parliament and the public of non-financial performance, and should present all information and analysis necessary to inform that assessment. Presenting results alongside targets, and providing comparisons to results from previous years or references to related indicators and results, can assist the reader in assessing performance.¹²

23. In other words, what a person or an organisation is accountable *for* is performance. That is, what has been done, what has been achieved, and the outcomes of activities against pre-determined goals, as indicated by data.
24. Chair of the Afghanistan Inquiry Implementation Oversight Panel, Professor Rufus Black, summarised the importance of accountability, saying:

if something has gone wrong, then each person in that system knows what their obligations are, rapidly, to own and to fix. A safety failure does require those at the highest level to be asking about the total safety system and how well – clearly, if it’s failed, how well it’s working or not.¹³

25. Professor Black said it was critical to establish a culture of organisational learning so that accountability for failures does not always equal blame, which undermines cultural change. He said:

Accountability in that sense is actually about owning a problem and owning the need to create change at whatever level.¹⁴

11.2.3 How should performance be assessed?

26. Performance measures determine whether organisations are delivering results against their own and (in this case) government objectives. This includes whether services or projects are delivered on time and are effective in achieving the desired outcome. In the words of the ANAO:

If entities reliably measure and report on the achievement of outcomes, Parliament knows if their investment of public funds has had the desired impact.¹⁵

27. Professor Black considered the role of organisational governance regarding war crimes. He noted the importance of defining performance measures against clear outcomes, saying this helps focus efforts to drive change:

Part of the difficulty of very large lists of recommendations and many goals is people struggle to know what to focus on. If the focus is clear, compelling, clear outcomes, then the system can be mobilised to drive those changes.¹⁶

28. Performance measures help organisations to focus effort and understand what is working, and what is not.

What to measure and how to measure it?

29. According to the ANAO, it is important to measure outcomes regularly when delivering large-scale, long-term initiatives:

This can be done by developing interim performance expectations backed by practical implementation plans. It may also be necessary to invest in developing new and improved data sources or more frequent data collections. Identifying what works and why it works helps drive towards better outcomes.¹⁷

30. The ANAO advises that effective monitoring, review and evaluation processes are essential for improving current practice and achieving change. It encourages organisations to continue to assess whether their performance measures are working, saying:

Targets should be specific, realistic and measurable. They should be revised regularly to reflect increases or decreases in funding, historical achievement, or productivity gains resulting from continuous improvement. Where targets have not been met, there should be transparent discussion to explain the reasons.¹⁸

31. Robust evaluation and performance measures must:

- be relevant, with a clear link to an entity's purposes or key activities
- relate to a clear methodology and be supported by data that is accurate, valid and sufficiently comprehensive
- reflect and fairly represent the entity's purposes or key activities
- provide an unbiased, simple basis for measuring and assessing performance
- reflect what the entity is trying to achieve, not simply what is measurable
- have an 'owner' to promote accountability and transparency.¹⁹

32. How performance is measured is of particular interest to us. As we will outline in this chapter, Defence has made some efforts to mitigate risk factors for suicide and suicidality among serving and ex-serving members. However, it has tended to measure performance based on what actions it took rather than whether those actions were effective.
33. If the organisation is committed to reducing suicidality and deaths by suicide, performance must be measured by whether its activities are actually reducing suicide and suicidality, or reducing the risk factors known to contribute to it.
34. As such, understanding what works and what does not work *against those precise objectives* is foundational. Without this information, it is impossible to know which suicide prevention strategies to enhance and scale up, and which are simply not working and should be redesigned or abandoned.

11.2.4 What does good risk management entail?

35. The ANAO's 'Risk Management' Audit Insights Report defines risk as 'the effect of uncertainty on the achievement of objectives, whether positive or negative'.²⁰ So defined, risk can entail opportunity as well as threat. The key to risk management is to eliminate or mitigate risks that might present hazards 'without eradicating, or unnecessarily hindering, beneficial risk-taking'.²¹ Risk is managed by identifying 'controls' that reduce the likelihood of a risk occurring and/or the negative effect of that occurrence.
36. Organisations should assess the performance of these controls to determine whether an action was undertaken to reduce or remove the risk, and if so, whether it was effective. An effective risk management framework monitors performance 'to ensure that objectives are being achieved and that control activities are operating effectively'.²²
37. The fundamentals of good risk management are:
 - establishing risk management frameworks that are approved by the accountable authority and aligned with the Commonwealth Risk Management Policy
 - having an organisational 'risk appetite' that is clearly defined and communicated
 - having policies, procedures and tools to operationalise the framework
 - clarifying the roles and responsibilities of people involved in risk management
 - ensuring that capability and resourcing are appropriate to the task
 - documenting risk management activities as appropriate.²³
38. Good risk management ensures that risks are identified early and can be eliminated or mitigated.

11.3 Governance and accountability in Defence

39. Defence's governance framework is founded on a concept known as the diarchy, a dual-leadership construct enacted by legislation that confers power to two entities: the Australian Defence Force and the Department of Defence.²⁴ The intent of the diarchy is to bring together military and public sector expertise, maximising the value of each discipline's 'culture, skills and experience'.²⁵
40. While we are primarily concerned here with outcomes for serving and ex-serving members based on the governance of the ADF, we note that these functions are enabled and supported by the Department of Defence.
41. 'Enterprise' structures and frameworks referenced throughout this chapter are those that apply to the Department of Defence and the Australian Defence Force.

11.3.1 The Defence Enterprise Committee Framework

42. Defence has a governance model to 'facilitate enterprise decision making and set the organisation's strategic direction'.²⁶ Called the Defence Enterprise Committee Framework, it was established in 2018 following the 2015 First Principles Review, the recommendations of which included:

A stronger and more strategic centre able to provide clear direction, contestability of decision-making, along with enhanced organisational control of resources and monitoring of organisational performance.²⁷

43. In July 2023, Defence released a document titled 'How One Defence Works'. It aims to align Defence's operating model with findings from the 2023 National Defence Strategic Review.²⁸
44. The Defence Enterprise Committee Framework, updated in April 2023, specifies under the heading 'Accountability' that:

Efficient decision-making is based on a balance between individual accountabilities and a One Defence perspective, where risks are identified and managed proportionate to the nature and severity of the potential impact.²⁹

45. The framework has three tiers of committees, allowing issues to be escalated and de-escalated, and decisions to be made at the relevant level.
 - The Defence Committee is the Tier 1 committee, representing the highest level of decision-making in Defence. It addresses issues that affect the whole of Defence as well as top-level organisational goals.³⁰

- Tier 2 committees include the Chiefs of Services Committee, the Enterprise Business Committee, the Investment Committee and the Strategic Policy Committee. They assess issues that affect military acquisition and operational preparedness, 'enabling' functions (such as human resources), and strategic policy and intelligence matters.³¹
 - Tier 3 committees include the Military Justice Steering Group, the Defence WHS Board and the ADF Health Select Committee. They assess issues that affect policy, and guide groups and services within the ADF to ensure that departmental policy is aligned to organisational priorities.³²
46. The Defence Audit and Risk Committee sits outside the tiered system. It supports the oversight of and assurance for the Secretary of the Department of Defence and the Chief of the Defence Force under the *Public Governance, Performance and Accountability Act 2013* (Cth).³³

11.3.2 How the Defence governance framework is applied

47. The ANAO encourages organisations to review governance arrangements periodically to ensure they continue to align with internal and external circumstances, and to identify areas for improvement.³⁴
48. Defence governance and accountability structures have been the subject of multiple reviews. The 2011 Review of the Defence Accountability Framework (the Black Review), the 2015 First Principles Review and the 2018 Defence Culture Evaluation all examined Defence's governance and accountability structures and processes.³⁵ They identified similar themes, including:
- that Defence has a 'complex accountability system' that is unclear and diffuses accountability³⁶
 - that Defence needs to improve individual accountability for projects, performance measurement and project management.³⁷
49. The 2021 Baseline Accountability Review noted that findings from the Black Review remained valid.³⁸ Based on this, Defence initiated the 2022 Proximity Review to review and assess the effectiveness of enterprise committees, and the effectiveness of their support to decision-making and accountability.³⁹
50. The resulting report was provided to then Chief of the Defence Force General Campbell and Secretary of Defence Greg Moriarty AO, in September 2022.⁴⁰ The reviewers found that:

Defence's approach to enterprise committees has an inverse impact on delegated decision-making, accountability and efficiency, and ultimately on the quality of this critical mechanism for public administration of Australia's national security.⁴¹

51. For clarity, an ‘inverse impact’ means that enterprise committees have had precisely the opposite effect on delegated decision-making, accountability and efficiency from what was intended.
52. In March 2024, Associate Secretary of the Department of Defence Matthew Yannopoulos PSM agreed that the Proximity Review ‘speaks to both leadership and structural failures at the enterprise level’.⁴² He said that Defence’s response to its 12 recommendations was not as ‘bold’ as the reviewers said it should have been.⁴³
53. He accepted, in line with the report findings, that ‘there is no systemic way that committees themselves followed through on accountabilities of individuals’.⁴⁴
54. To put these findings in context and begin to tease out their implications for aspects of workplace culture, such as trust in leaders, we turn to Mr Peter Dunn AO, a former serving Major General in the Army who conducted the Defence Efficiency Review in the 1990s.
55. Mr Dunn talked about the critical importance of all leaders of an organisation being personally accountable (for their remit). In response to a question about the role of accountability in fostering good leadership and governance, he said:
- Leaders are absolutely accountable in every respect for taking that responsibility down through the organisation. And men and women in the organisation, whether it’s a private enterprise ... Defence, or ... emergency services, they need to know that their leaders have their back and will step up and take accountability for those leadership elements ... It is absolutely essential that leaders know they are going to be held accountable ... This is the mantle that you take on when you become a leader at any level, that you are going to be held accountable for your actions.⁴⁵
56. We highlight throughout this chapter that lack of personal accountability and other governance issues have undermined Defence’s ability to reduce psychosocial harm and proactively address suicide and suicidality among serving and ex-serving members.

11.4 How governance and accountability relate to suicide and suicidality

57. Structures and processes of governance and accountability in the ADF are relevant to suicide and suicidality among serving and ex-serving members.
58. The management of functions associated with governance (accountability, strategic planning, risk management, organisational performance and continuous improvement) shapes decision-making at all levels of the organisation. These are decisions about what the organisation considers most important, its priorities, how to fulfil its priorities, its ‘risk appetite’, and how risk is managed.

59. For Defence to be a 'learning organisation', which is an important capability in uncertain times, decision-makers such as senior leaders and commanding officers need to have:
- timely and accurate information that tells them what is happening in the organisation and where risks are emerging, so they can be identified early and addressed (risk management)
 - a shared sense of direction and purpose, including agreement on what constitutes enterprise-level risks and how they should be managed (strategy and risk management)
 - performance measures that help them understand where the organisation is heading and what success looks like, and that communicate where additional effort is needed (performance measurement)
 - an understanding of who is accountable for what, and when risks and issues should be escalated (accountability)
 - a reporting culture that encourages people to speak up about risks and problems without fearing they will be blamed or 'thrown under the bus' (culture and compliance).
60. Defence has been aware of the prevalence of suicide and suicidality among serving and ex-serving members for some time. In August 2003, a briefing note for the then Chief of Army stated:
- In the last 12 months, a significant amount of resources have been directed by the ADF to the problem of mental health generally and suicide in particular. The key elements being the creation of the DMH [Directorate of Mental Health] and the release of the ADF MHS [Mental Health Strategy], which addresses various mental health issues, including suicide and related behaviours.⁴⁶
61. In November that year, the Defence personnel executive wrote to the Minister Assisting seeking funding for suicide intervention training. They raised concerns that a leading cause of death among ADF personnel was suicide.⁴⁷
62. In 2010, the ADF Mental Health Prevalence and Wellbeing Study estimated that in the previous 12 months, members serving full time in the permanent forces experienced higher levels of suicidal ideation and planning compared to the general population (matched for age, sex and employment status).⁴⁸ The study raised concerns about suicide risks for serving members.⁴⁹
63. The 2016 Kinghorne Review, commissioned by the then Chief of the Defence Force, stated that:
- despite the significant time, money and other resources expended by Defence on mental health in the past 10 or more years, serving members have continued to take their own lives.⁵⁰

64. While we recognise that Defence has undertaken various initiatives aimed at improving the mental health and wellbeing of its members,⁵¹ this has historically been underpinned by the belief that service is a protective factor against suicide and suicidality.
65. As we discuss in Chapter 1, Understanding suicide, while service can be a protective factor for some, there are elements of service life that are risk factors for suicide and suicidality for others. Furthermore, certain aspects of service – such as a strong military identity and connection to the unit, stoicism and self-reliance, and the capacity to suppress emotion – can be protective during service but become risk factors following separation. Recognition that experiences and stressors associated with service can contribute to suicide risk must inform how Defence targets its interventions.
66. Notwithstanding recent changes within Defence, including the establishment of the Chief of Personnel and the Mental Health and Wellbeing Branch (see section 11.7),⁵² the historical context for current arrangements is important, including to ensure that lessons are learnt and carried forward. Acknowledgement of what occurred in the past also offers much-needed transparency for families and friends who have lost a loved one to suicide.
67. The following section highlights how data limitations affect governance processes, something we discuss in more detail in Chapter 29, Use of data and research by Defence and DVA. Defence has also been slow to acknowledge the risk factors associated with service that contribute to suicide and suicidality. We highlight the need to improve risk management, accountability and performance assessment in Defence, and to tackle service-related risk factors. We argue that strategy must move beyond focusing solely on transition-related risk factors and consider in-service risks.

11.4.1 Data limitations affect governance

68. Without good data, it is impossible to identify trends and understand the underlying causes of problems, which helps to identify risks and set strategic objectives within an organisation. Data contributes to the evidence base, which in turn informs decision-making.
69. Chapter 29, Use of data and research by Defence and DVA highlights the longstanding limitations of Defence's data systems and capacity for data analysis. For more than two decades, despite efforts to improve its data collection and analysis, Defence has conceded that the data available to it remains imperfect.⁵³
70. In 2021, the evaluation of the Defence Mental Health and Wellbeing Strategy 2018–2023 undertaken by the University of Canberra noted as a key finding that 'the advances in Defence mental health and suicide prevention activity have not been matched by advances in robust, evaluation-suitable, data to demonstrate positive impact from that activity'.⁵⁴ In other words, Defence has done a lot but is not able to determine whether it has been effective.

71. In December 2023, the University of Canberra prepared the *Defence Mental Health and Wellbeing Strategy and Continuous Improvement Evaluation* report, which found:

The lack of comprehensive and timely data on suicide and suicidality in Defence poses a major challenge to building the evidence base.⁵⁵

72. The preliminary findings urged that more effort be made to establish a suicide database, improve regular monitoring and reporting, and invest in appropriate data skills.⁵⁶

73. Associate Secretary of Defence, Matthew Yannopoulos, commented that ‘having access to timely data is a serious and significant challenge for Defence’.⁵⁷

74. In connection with mental health and wellbeing, Mr Moriarty expressed disappointment that Defence had not been able to change some of its underlying statistics and its initiatives had not produced the visible improvements he had hoped for.⁵⁸

75. In just three years, this Royal Commission has managed to identify specific cohorts of serving and ex-serving members associated with higher rates of suicide that we do not believe have previously been identified. We discuss our analysis and findings in Chapter 1, Understanding suicide.

76. The ongoing need to improve data collection and management, the ADF’s lack of progress in acknowledging and addressing in-service risk factors for suicide, and its lack of monitoring of existing services and programs, means its strategies and efforts have overlooked harm that continues to occur. As a result, it has not made plans to reduce the impact of that harm and improve safeguards, which we discuss further in section 11.4.6.

77. We welcome a recent development where Defence will collaborate with research organisations to give greater attention to the risk and protective factors associated with service in the ADF:

Defence has partnered with the World Health Organization Collaborating Centre for Research and Training in Suicide Prevention and the Australian Institute for Suicide Research and Prevention to develop a research framework to assess risk and protective factors for suicide in the ADF with the aim to further inform and enhance current and future prevention programs.⁵⁹

78. Defence also advised us that since the University of Canberra’s findings on its data limitations, it has taken steps to improve the monitoring and evaluation of wellbeing programs. This includes establishing an assurance and evaluation directorate within the Mental Health and Wellbeing Branch.⁶⁰ These are positive steps; however, we are unable to comment on their effectiveness.

79. Chapter 29, Use of data and research by Defence and DVA also highlights the progress in research and data analysis underway in Defence to better understand suicide and suicidality. However, as we point out, while ‘there is data available (collected, entered and accessible) it is often not used [to inform decision-making]’.⁶¹ These research programs are positive, but effort is also needed to translate the findings into meaningful change.
80. Chapter 29 makes a number of recommendations to improve data collection and analysis in Defence.

11.4.2 Defence has only recently acknowledged risk factors associated with ADF service

81. The ANAO highlights the importance of acknowledging problems to support good governance, stating:

Openness to criticism and learning plays an important role in building an effective culture, whether it be in supporting an innovative culture, a risk management culture or a compliance culture. Organisations that respond to external criticism defensively or dismissively (‘we are already aware of the issue’, ‘we are already addressing the issue’, ‘the report needs to be read in context’, ‘the issues raised are not material’) put at risk their ability to build an effective governance culture and embed the characteristics of a learning organisation.⁶²

82. The fact that serving in the ADF contributes to suicide risk has only recently been acknowledged by Defence.⁶³ The insistence, prior to that, that ‘protective factors ... tend to dominate, to overshadow the risk factors in play while in service’⁶⁴ has been a barrier to driving meaningful change.
83. This testimony in 2022 of the then Chief of the Defence Force, General Campbell, emphasised the strong protective factors associated with service and claimed the greatest risk was during and post transition.⁶⁵ While we agree with General Campbell that there are many protective factors associated with service, interactions between risk and protective factors are a lot more nuanced than his statement seems to suggest.
84. First, the fact that the greatest risk is felt by members in transition and post-service does not mean that the harm that contributed to their suicidal distress was not incurred during service.
85. Second, the mode of a member’s separation (voluntary or involuntary) and the circumstances surrounding separation are known to significantly affect wellbeing. Saying that ‘protective factors tend to dominate during service’ when the mode of separation itself can be highly injurious gives an incomplete, even false picture of the risk factors associated with service compared to post-service life.

86. Third, one might read into General Campbell's assertion the unspoken implication that anything that happens post-service is not the ADF's problem or concern. Given the sheer number of submissions and testimonies we heard from ex-serving members who reported feeling abandoned, betrayed, stigmatised, cast out or worthless to the ADF when they were no longer 'useful' suggests that, true or not, this is many people's perception.
87. Lastly, our statistical analysis that compared suicide rates among serving members with those of employed Australians (a more accurate comparison, since serving members are by definition employed) identified a range of risk factors contributing to suicide and suicidality among serving and ex-serving members. We discuss this in Chapter 1, Understanding suicide.
88. Tragically, it is not the case for all people that the protective factors dominate. In March 2024, General Campbell accepted, in the face of emerging evidence, that for some people service is not protective, but causes members harm.⁶⁶
89. Then Vice Chief of the Defence Force (now Chief of the Defence Force) Vice Admiral David Johnston AC RAN agreed that the first step to solving the problem is acknowledging that it exists.⁶⁷
90. Then Chief of Airforce Air Marshal Robert Chipman AO CSC (now Vice Chief of the Defence Force) also accepted that service may not be protective of suicide and suicidality. He said that until recently, Defence more broadly did not believe it had a problem with suicide or suicidality. Chief of Navy Vice Admiral Mark Hammond AO RAN, in his testimony, agreed.⁶⁸
91. Chief of Army Lieutenant General Simon Stuart AO DSC gave evidence that for some members service is a 'negative experience for whom the impact is pernicious, can be lifelong, can be life-altering or, indeed, life-ending'.⁶⁹ He added:

Defence has not sought to target any particular population sub-group with its suicide prevention initiatives on the basis that universal measures are likely to provide the best protection.⁷⁰
92. These recent acknowledgements go some way to revealing why Defence has not prioritised or effectively targeted efforts to better understand the risk factors for suicide and suicidality associated with service. It did not believe there was a problem.
93. The Commonwealth disagreed that Defence had only recently acknowledged that service contributes to suicide risk and that this had been a barrier to driving meaningful change, stating:⁷¹

the Commonwealth acknowledges that the awareness of risk factors to suicide and suicidality affecting ADF members and veterans has substantially increased within many groups within Defence (including the ADF) over the last three years.⁷²

94. The Commonwealth also cited a number of efforts as indicative of Defence's longstanding awareness, including the Suicide Prevention Program, in place since 2002, and the Longitudinal ADF Study Evaluating Resilience (LASER-Resilience).⁷³
95. This stance is made despite the testimony of the Chief of the Defence Force in 2022, highlighted earlier, that protective factors 'tend to dominate' and 'overshadow' the risk factors at play in service, only for him to acknowledge in 2024 that there are instances where service is not protective but causes members harm.⁷⁴
96. While we recognise that some suicide prevention efforts have been made, the existence of programs and research alone does not equate to a strong, organisational understanding of stressors and risk factors for suicide associated with service. We believe it is important to acknowledge that when an organisation has not owned being part of a problem, then that is a barrier to prioritising change.
97. It remains our strong view that this recognition constitutes a recent change. It is one we welcome as a positive step forwards in addressing risk factors for suicide and suicidality associated with ADF service.

11.4.3 Accountability in Defence for member wellbeing has been unclear

98. Clear accountability and strong mechanisms for accountability are an essential part of good governance. We have found, in Defence, a lack of clarity on who is and has been accountable for delivering mental health and wellbeing outcomes and previous reforms. We acknowledge that it is difficult to be accountable for outcomes if they are not measured in the first place. We also acknowledge that it is difficult to measure outcomes when data collection is so problematic.
99. We have heard statements in which leaders have owned that they are accountable for psychosocial harm done to serving members. When asked about responsibility and accountability for minimising physical, psychological and social harm arising from service, then Chief of the Defence Force General Angus Campbell confirmed:
- It's command; it is my responsibility, my accountability. In this, the secretary and the functions that he has responsibility for are in support to that accountability. I am accountable and commanders are accountable.⁷⁵
100. Brigadier Nicholas Foxall AM DSM also noted that 'any commander or leader is acutely aware of their responsibility to ensure physical and mental wellbeing of their people'. However, this 'responsibility is described in an uncountable number of documents, orders, manuals, directives, policies and expectations'.⁷⁶

101. The Commander of the 1st Brigade and Senior Australian Defence Force Officer at Robertson Barracks advised us:

While there are no such specific KPIs relating to persons within the command structure, I consider that ensuring our people have access to, and are able to seek, the help and support they need, when they need it, is a good indicator of performance requirements in this regard.⁷⁷

102. Our concern is the lack of documented accountability. The absence of health and wellbeing performance metrics directly limits both transparent accountability when things go wrong (for example, stubbornly high suicide rates among serving and ex-serving members) and when seeking to assess which outcomes have been achieved.
103. In our view, unclear accountability for managing and improving mental health and wellbeing risks leads to a lack of focus on these issues. When accountability is clear, transparent and measured, individuals and teams take assertive responsibility for driving efforts.
104. The 2015 First Principles Review, the 2021 Baseline Review and the 2022 Proximity Review analysed Defence governance and accountability structures and identified issues with diffuse accountabilities across Defence's governance framework.⁷⁸

Confusion of responsibility and accountability

105. In our final hearing, Mr Yannopoulos confirmed that he had heard of concerns within the organisation regarding a lack of accountability mechanisms. He said he created the Defence Strategic Accountabilities Table to document the accountabilities that do exist in the system.⁷⁹
106. However, in reviewing the table we found it contained a list of responsibilities that was highly task focused rather than being outcomes focused, which, as we explained earlier, is the crux of accountability. Mr Yannopoulos acknowledged that the accountabilities table did not include measurable responsibilities or details of how they are delivered.⁸⁰
107. Defence Secretary Greg Moriarty also recognised that there were no outcome-based measures in the accountabilities table by which tasks could be assessed as complete.⁸¹ He disagreed that this meant there was no meaningful accountability, saying he assessed accountability based on a range of inputs and used data as an input and trigger for further discussion.⁸² This is a concern, given the significant issues with the collection, sharing, analysis and use of data by Defence that we have highlighted throughout this report.
108. In response to a procedural fairness notice, the Commonwealth stated that 'the absence of certain features from the Table, does not mean that those features do not exist within Defence'.⁸³

109. While we recognise that the table is only one means of documenting accountabilities, it is one that leaders have repeatedly referred to in explaining how accountabilities are understood. The Associate Secretary accepted the proposition that the accountabilities table did not reflect any measurable delivery of responsibilities (which is a de facto definition of accountability) and stated no such document existed.⁸⁴

The potential for improving accountability through the new branch

110. We acknowledge that Defence has started to address some of the issues we identify in this chapter by creating the Chief of Personnel role and establishing the Mental Health and Wellbeing Branch (the MHW Branch). The Chief of Personnel, a three-star role, was established to centralise the ADF's personnel management into a single integrated system, enterprise people strategy and policy framework.⁸⁵
111. The MHW Branch will be responsible for various activities to do with suicide monitoring, and data collection and analysis, and is led by the Director General of Mental Health and Wellbeing. The Director General's role, a one-star position, was created in June 2022 as the enterprise lead for mental health across Defence, with responsibility for establishing the MHW Branch. This included establishing a charter, determining the branch structure, and creating supporting governance procedures.⁸⁶
112. We discuss the creation of the MHW Branch and the establishment of the Chief of Personnel role in more detail in section 11.7.1.

Defence's performance management framework

113. Through the procedural fairness process, Defence stated that its Performance Logic Model fulfils the intent of an enterprise performance management framework.⁸⁷ The model describes the link between Defence's outcomes, strategic objectives, key activities and targets in accordance with the Commonwealth Performance Framework.⁸⁸
114. The Performance Logic Model represents a positive step towards addressing a lack of transparency regarding accountability for mental health and wellbeing as it relates to suicide and suicidality in Defence. However, as these initiatives were underway at the time of drafting the report, we cannot comment on their effectiveness.

11.4.4 Performance measures communicate what is important

115. We explore performance management and measures of performance in two places in our final report:
- performance measurement as it relates to the effectiveness of Defence's strategy, policy, services and projects, in this chapter
 - performance management as it relates to individual accountability for delivering strategy, policy, services and projects, in detail in Chapter 7, Culture and leadership, and to a lesser extent in this chapter.

Managing benefits and outcomes

116. 'Benefits management' is a project management term that describes a methodology for monitoring and measuring the effectiveness of change. 'Outcomes measurement' is the term more commonly used in policy settings. However, both terms describe a process with the same intent: determining whether desirable change has been achieved.
117. We use both terms, depending on whether we are looking at policies and programs, or project management.
118. Defence has acknowledged the importance of measuring the benefits of reforms that have been delivered. For example, Air Vice-Marshal Barbara Courtney AM, Head of the Royal Commission Taskforce, Department of Defence, stated that 'benefits realisation' is the term used to determine how 'you measure whether an initiative has worked'.⁸⁹ She explained that delivering an initiative in response to a recommendation is one part of the process, with the second part being ensuring that the intent of the recommendation has been met.⁹⁰
119. A July 2021 briefing to the Defence Business Committee also noted that it was important to determine whether a program had met its objectives and been implemented effectively and whether there were any issues. They categorised this as 'benefits management', saying it was:

an integral part of effective program and project management. The discipline of benefits management has broader application than reform. It assists in justifying and particularising why we commit finite resources to activities. Benefits measures can also assist in providing assurance of program performance, monitor capability realisation and provide early warning of risks and issues.⁹¹

A significant issue is that Defence measures activity rather than evaluating outcomes

120. Despite a lot of new terminology and impressive-sounding methods, the crux of the matter is that Defence has a very poor track record of determining whether its reforms are effective in bringing about desired outcomes. A lot of these reforms are delivered in response to various reviews that make recommendations. As such, what we are discussing is that the onus is on Defence to determine whether its activity can be said to have 'implemented the recommendation' and whether its activity has been successful in realising the intent of the recommendation.

121. Defence has been subject to many reviews into its governance and accountability structures. All reviews identified persistent issues, including that reforms were only partially implemented, their effectiveness was not adequately measured, and there was a lack of accountability for the outcome.⁹²
- The 2014 evaluation of the Dunt Review of Mental Health Care in the ADF, for example, criticised the lack of performance measurement and lack of evidence of continuous improvement.⁹³
 - Three years later, in 2017, the National Mental Health Commission Review into suicide and self-harm prevention services available to current and former serving ADF members and their families noted ‘remarkable and concerning’ consistency between the findings of the 2014 evaluation of the Dunt Review implementation and its own findings.⁹⁴
122. Another four years later, in 2021, Dr Bernadette Boss CSC said in the *Preliminary Interim Report* of the Interim National Commissioner for Defence and Veteran Suicide Prevention that the implementation of recommendations had to be monitored and evaluated:
- Long-term monitoring and evaluation is essential to ensure the effective implementation of recommendations and to measure the effect of implemented changes within different risk groups. This is particularly important due to the complexity of suicide. It takes time to develop and implement policies aimed at preventing suicide and even longer before improvements in the suicide rate resulting from effective changes will become apparent.⁹⁵
123. Associate Secretary of Defence Matthew Yannopoulos was asked about the implementation of the *Pathway to Change* report recommendations. In 2018, Rapid Context consulting was contracted by Defence to undertake a deep dive report into Leadership Accountability, as one of the core culture reform priority areas identified under the Pathway to Change (PTC) Culture Evaluation Framework. The review found that while accountabilities were generally clear and well understood, accountability could be strengthened through greater clarity in expectations of how leaders work together (‘horizontal’ accountability)⁹⁶. The review noted committees ‘as sites where accountability becomes diffused’.⁹⁷
124. Mr Yannopoulos agreed that outcomes-based performance measures were not included and accepted the premise that ‘measurement needs improving’.⁹⁸
125. To justify why outcomes were not being assessed, Mr Yannopoulos said they were difficult to measure, telling us:
- It is easy – or it’s easier to measure inputs, it’s slightly more difficult to measure outputs and more difficult still to measure outcomes – and when an organisation like ours doesn’t have great systems with good data, it is made even more difficult.⁹⁹
126. Defence Secretary Greg Moriarty noted that without quality data, outcomes are difficult to define and measure.¹⁰⁰

127. Lieutenant General Fox AO CSC,¹⁰¹ Vice Admiral Hammond AO RAN,¹⁰² Lieutenant General Stuart AO DSC¹⁰³ and Air Marshal Chipman AO CSC¹⁰⁴ all acknowledged that Defence needs to move towards measuring outcomes, defined as ‘the change that Defence wants to see’¹⁰⁵ and said this was possible.
128. Then Vice Admiral Johnston agreed with the statement that ‘it’s not just enough to enact a solution, you need to ensure it’s been implemented and measure whether that solution is effective.’¹⁰⁶
129. We are glad to hear senior leaders in Defence acknowledge the importance of evaluating outcomes. This recognition has not come too soon. If there is a degree of exasperation and frustration that creeps into our tone, it is because Defence has known for 21 years that it needs to improve its data on service-related risk factors for suicide and suicidality. Many precious lives have been lost to suicide in this time. We explore these issues in more detail in Chapter 1, Understanding suicide, and Chapter 29, Use of data and research by Defence and DVA.
130. Giving responsibility to the new Mental Health and Wellbeing Branch to drive the evaluation of activities to improve member wellbeing using quality data is a positive step.
131. Defence partnered with the University of Canberra in November 2020 to establish the Continuous Improvement Framework Project to provide a systems-based approach to monitor, evaluate and improve mental health programs.¹⁰⁷ We also note the intention of the Continuous Improvement Framework to provide a systemic approach to monitoring, evaluating and improving mental health programs. We highlight, however, that there is a difference between evaluating services (which are part of business as usual) and evaluating projects (which seek to drive change).
132. The Defence and Veteran Mental Health and Wellbeing Strategy 2024–2029 states Defence’s intention to develop a monitoring and evaluation framework that ‘sets out what that Strategy’s success looks like in the form of short, medium and long-term outcomes’.¹⁰⁸ We are unable to comment on the framework, which is still in development at the time of writing this report.
133. We observed recent efforts to embed outcomes in the Work Health and Safety (WHS) Strategy Implementation Plan. In August 2023, Defence produced a draft implementation plan for improving WHS risk management. The plan has a measurement and evaluation framework, including key performance indicators for improving psychosocial outcomes. The measures are predominantly output based (for example, measuring training completion) but also include outcome measures collected through pulse surveys and by analysing retention rates.¹⁰⁹
134. However, there is no reference to suicide or suicidality, or to mental stress, which is something we discuss in detail in Chapter 13, Oversight of Defence workplace health and safety.
135. Defence has told us it has a methodology for measuring ‘benefits realisation’ and appears to be improving in willingness and capability to evaluate the outcomes of its programs and projects, as we discuss further in section 11.7.

136. We acknowledge that measuring performance in relation to mental health and wellbeing is complex. We also recognise that some delay between implementation and effect is expected and acceptable; outcomes of more recent interventions may not be visible for some years to come.¹¹⁰ This makes it all the more important, however, for Defence, and the Australian Government more broadly, to give sustained attention to measuring the effectiveness of mental health programs and strategies to reduce psychosocial harm.

The Portfolio Budget Statement and Annual Performance Statement

137. The Portfolio Budget Statement outlines the activities Defence will undertake to achieve its stated outcomes. Each year, an Annual Performance Statement is tabled in Parliament to report on the Defence Portfolio achievements against those outcomes.
138. In 2022–23, Defence introduced a new performance measure to the *Defence Annual Report*:

Performance Measure 4.2: Defence supports Australian Defence Force members and their families by providing access to the right support, at the right time, enabling service personnel to be Fit to Fight, Fit to Work and Fit for Life.

Target 4.2a: Defence continues to strengthen support for whole-of-life health, wellbeing and safety outcomes for current and former Australian Defence Force members and families through the delivery of support services that address the Defence and Department of Veterans' Affairs Wellbeing Framework.¹¹¹

139. As this is the first year in which the new measure applies, we have no data on it.¹¹² Until baseline data is established against which progress can be assessed, its performance cannot be confirmed. It is disappointing that in 2024, Defence is only just beginning baseline assessments of key wellbeing categories despite a long history of interventions that should have delivered meaningful insights long before now.
140. In response to a procedural fairness notice issued in June 2024, the Commonwealth stated that:
- Defence will amend Performance Measure 4.2 in the Portfolio Budget Statements 2024-25 to include specific reference to lifetime wellbeing. Defence also plans to revise the related targets for Performance Measure 4.2 in the 2024–28 Defence Corporate Plan, which will be released no later than 31 August 2024 in accordance with the *Public Governance, Performance and Accountability Act 2013*.
141. This public commitment to measuring performance will place sustained pressure on Defence to continue to improve its practices around data collection, storage and analysis, and to use the findings of that analysis.

The choice of what to measure and what not to measure is highly significant

142. Performance measures help shape organisational behaviour, meaning that the choice of what to measure and what not to measure is significant. Performance measures incentivise certain decisions and can create unintended consequences that undermine the fulfilment of a larger objective.¹¹³ This is sometimes called ‘the performance paradox’.¹¹⁴ Leaders understandably focus their activities on what is going to be measured and assessed, and when this leads to a fixation on isolated measures rather than a focus on the broader goal, outcomes tend to be poor.¹¹⁵
143. Performance measures can also create undesirable behaviours in leaders who fixate on meeting targets whatever the cost, with an ‘ends justify the means’ mentality.¹¹⁶ Similarly, a fixation on targets can also mean that decisions are made at an enterprise level that carry undesirable consequences, including for member wellbeing.
144. An example of this is Defence’s decision to relax physical fitness entry requirements and grant more medical waivers that permit candidates to enlist who would not otherwise meet minimum physical and/or psychological standards.¹¹⁷ These decisions have been made, in part, in an attempt to meet annual recruitment targets, which have not been fully achieved in any year since 2006.¹¹⁸ The 2023 Defence Strategic Review identified recruitment and retention as one of its six key priorities and recommended changing policy and risk settings ‘to improve the achievement of recruitment targets by 2024’.¹¹⁹
145. While the review describes this as a change in ‘risk appetite’,¹²⁰ it raises the question: who bears the consequences of that risk? A trial conducted by the Army in 2021 and 2022 found that members who entered service under the reduced pre-entry fitness assessment standards were 35% more likely than non-combat standard entry recruits to access physiotherapy, and 85% more likely to have accessed mental health support since enlistment.¹²¹
146. Further to this, Professor of Physiotherapy at Charles Sturt University Rodney Pope told us that ‘aerobic fitness was quite a strong predictor of injury risk, and [is] particularly important for those at the lower end of fitness levels’.¹²² As such, the evidence suggests that people who enlist under reduced entry standards are at greater risk of physical injury and of needing mental health support. Furthermore, being physically injured can lead to medical separation and medical separation is a risk factor for suicide and suicidality, as is shorter length of service.
147. The trajectories of waiver recipients – including rates of injury and early separation, and mental health outcomes – are not known because Defence does not track their performance or wellbeing.¹²³

148. We discuss this more fully in Chapter 3, Recruitment and initial training, but wanted to mention it here in the context of performance metrics specifically, and governance more generally. This example demonstrates that a unilateral focus on a particular performance metric (here, a recruitment target), to the exclusion of the broader picture, can and does have stark consequences for member wellbeing.

A new, integrated approach

149. Defence has taken some steps towards recognising gaps in its processes for managing performance and has committed to improving performance management across the enterprise. In response to a procedural fairness notice, the Commonwealth stated:

Throughout February and March 2024, initial scoping activities for the integrated performance, risk and planning approach were completed. These activities indicated that a connected and incremental approach to integrating performance, risk and planning was required.¹²⁴

150. We welcome this development, given the significance and complexity of the task ahead. Since assessing and measuring outcomes represents a new step for Defence, we recommend it seek guidance from performance measurement experts to help lift performance management and measurement across Defence.

Recommendation 38: Improve governance processes related to accountability and continuous improvement

To improve accountability and continuous improvement regarding mental health and wellbeing outcomes, Defence should:

- (a) continue to work towards including health, wellbeing and safety measures in its Budget Paper performance measure, and ensure these measures cascade into future corporate plans
- (b) prioritise developing the Monitoring and Evaluation Framework in partnership with the Department of Veterans' Affairs, for inclusion in the joint Mental Health and Wellbeing Strategy 2024–2028, and set out what success would look like for that strategy in terms of outcomes in the short, medium and long term, against the wellbeing domains
- (c) continue to develop a clear performance logic, including the translation of performance measures from budget papers, the corporate plan, and the joint strategy into clear accountability measures for senior leaders in Defence
- (d) once the Enterprise Reform Program has been implemented, assess how improvements in the collection, sharing and use of data may better support performance measurement, in line with the Defence performance logic model.

Acknowledging the challenges in improving performance measurement, and the risk of unintended consequences, the Australian Government should assist Defence to build performance management experience and expertise at the unit, service and enterprise level by:

- (e) prioritising Defence in the broader APS performance management capability uplift
- (f) prioritising Defence in the Australian Public Service Commission Capability Review program
- (g) supporting a coaching and mentoring program in areas (identified by Defence) which have responsibility for developing and implementing reforms in performance measurement.

11.4.5 Managing risk related to suicide and suicidality

151. The Defence Risk Management Framework helps Defence uphold its ‘organisational obligations and responsibilities under the *Public Governance, Performance and Accountability Act 2013* (the PGPA Act) Commonwealth Risk Management Policy’.¹²⁵

152. Defence recognises that risk management is an ‘essential element of Defence’s governance and internal control environment’,¹²⁶ stating:

Understanding of our exposure to risk should inform decision-making, improve performance and delivery of objectives and outcomes. The risk management process also allows Defence to design and tailor controls (in the form of rules and standards) and take mitigating actions to manage risks.¹²⁷

153. In our inquiry, however, we have found that limitations of Defence’s risk management system, coupled with data limitations, mean that Defence does not have the optimal environment to improve wellbeing outcomes.

154. Defence advised us that its Risk Management Framework has been redesigned to be consistent with the PGPA Act, Commonwealth Risk Management Policy and ISO31000 risk management standards. The framework is supported by the Defence Risk Policy.¹²⁸

Limitations of Defence’s enterprise-level risk management system

155. We recognise that Defence has implemented systems for risk management, including a risk management framework intended to ‘embed risk into the fabric of Defence business’.¹²⁹ However, the existence of a framework alone does not equate to an effective approach; the monitoring, performance and transparency of risk management systems are crucial to their operation.

156. Several reviews of the Defence Enterprise Governance Framework have identified issues with the risk management system.¹³⁰ The most recent of these reviews, the 2022 Proximity Report, observed that:

- risk management was not suitably performed in the majority of Enterprise Committees. Examples of inadequate risk management include:
 - committee papers failing to account for risk
 - discussions in committees failing to raise risks or their management, and guidance back to business lines on appropriate risk considerations
 - the Enterprise Committee Governance Framework failing to raise risk as an important function of committees
 - [that] there is limited management of the mitigating actions to address risks.¹³¹

157. The report stated that current practices of escalating issues to higher-level committees tended to be based on ‘gut feel’ and/or ‘a desire to avoid accountability for negative outcomes’. The result of these practices was given to be that ‘the best outcome that can be achieved is that the right issues might be escalated by chance’.¹³²
158. This finding of the Proximity Report is profoundly concerning on several levels, not least of which being that a willingness to accept accountability is a foundation of good leadership.
159. In November 2023, the Enterprise Business Committee was told that the enterprise risk system is ‘not fit-for-purpose and does not contribute to decision making nor to the corporate performance measure’.¹³³ The Committee was asked to ‘agree to the requirement for an integrated performance, risk and planning approach at the enterprise level’.¹³⁴
160. Associate Secretary of Defence Matthew Yannopoulos, who is also the Chief Risk Officer and Chair of the Enterprise Business Committee, agreed that controls are critical to enable or minimise risk.¹³⁵
161. He also explained the impact of having no centralised performance mechanism, saying it makes it harder to assess interdependencies between activities of the department, make judgments about resource allocations (both people and financial), and judge whether Defence’s risks are being mitigated in the right way.¹³⁶
162. Mr Yannopoulos agreed that ‘there continue to be challenges in assessing how Defence performs against enterprise priorities’.¹³⁷ He explained:
- in the absence of data that supports our decision making, we need to do it through professional judgments [and] discussion, and try and form the best view we’re able of how to allocate the resources of the Defence enterprise.¹³⁸
163. In its November 2023 report, the Afghanistan Inquiry Implementation Oversight Panel found that Defence lacked operational curiosity regarding indicators of risk. The panel found that Defence had ignored multiple sources indicating that matters in Afghanistan required attention – including rumours, operational reporting, and reports by media and non-government organisations and local people. The panel criticised Defence for its lack of curiosity and the absence of formal and consistent risk management practices and reporting.¹³⁹
164. Our inquiry found similar issues with Defence in relation to risks associated with suicide and suicidality among serving and ex-serving members. Defence has a history of arguing that service is protective despite findings of many reviews to the contrary and despite large numbers of veterans indicating otherwise.
165. The broader issues with Defence’s enterprise risk management approach have reduced its ability to identify and take action to eliminate or mitigate risk factors for suicide and suicidality that affect its members day in, day out.

How does Defence manage risk factors for suicide and suicidality?

166. Risks to serving ADF members and Defence employees are managed through the Enterprise Risk Management Framework, and the Work Health and Safety system. Chapter 13, Oversight of Defence workplace health and safety, discusses this in more detail.
167. Chapter 1, Understanding suicide, outlines a range of service factors that contribute to increased risk of suicide and suicidality.
168. The categories ‘workforce’ and ‘work health and safety’ are enterprise-level risk categories.¹⁴⁰ The work health and safety risk category includes a sub-category ‘psychosocial harm’ and is managed through work health and safety governance processes. Information on this category of risk is reported to the Enterprise Business Committee in the *Enterprise Work Health and Safety Focus Areas Report*.¹⁴¹
169. This report provides statistics on suicide and attempted suicide as part of the psychosocial harm category, but includes no analysis of these figures.¹⁴²
170. Asked about why psychosocial health was only considered in the context of work health and safety risks, and not in the workforce category, Mr Yannopoulos said, ‘I think it’s evidence that supports [that] our enterprise risk system is still not done’.¹⁴³ He also said that there was no reason why the report could not also consider psychosocial risks in the workforce category.¹⁴⁴
171. Without a dedicated focus on known risk factors for suicide and suicidality among ADF members, there is no mechanism for managing them. When risks are not identified and mitigated – or worse, when they are known and ignored – the harms associated with those risks are ultimately borne by ADF members.
172. In responding to a question in November 2023 about why the enterprise risk system needed attention, Mr Yannopoulos said:
- there is an ineffective synthesis of risks emerging in risk steward areas that can be ... brought together for either the Enterprise Business Committee or Defence Committee to make decisions upon. So, I guess I’m distinguishing risk processes that exist in our various ... projects or accountable areas and the capacity to bring them together at an enterprise [level] and say, ‘Are the mitigations working effectively?’ It is still not systemic and it’s not ... what we want.¹⁴⁵
173. In Chapter 13, Oversight of Defence workplace health and safety, we discuss what we believe to be the inadequacies in the way Defence risk assessment and controls reflect the evidence base.

11.4.6 Defence strategies miss the mark on service-related risk factors

174. An organisation's risk management processes inform its strategic planning and resourcing to tackle high-priority problems. An organisation's strategic plans direct the allocation of its budget, human resources and efforts.
175. A robust evidence base, consisting of both research findings and data, is essential to strategy development as it informs risk assessment and identification and decision-making on how to mitigate risks. Chapter 29, Use of data and research by Defence and DVA, highlights the ways in which Defence underutilises data to inform decision-making.
176. In 2023 (that is, while this Royal Commission was underway), we saw a range of documents that were intended to inform Defence strategy that, in our view, did not adequately identify and address risk factors for suicide and suicidality.¹⁴⁶ We observed evaluation and gap analysis reports with findings that did not align with those of previous reviews and, contrary to those findings, showed Defence's performance in relation to wellbeing programs in a positive light.¹⁴⁷
177. We discuss these sources in the following sections.

The 2023 Protecting Lifetime Wellbeing initiative

178. The 2023 Protecting Lifetime Wellbeing initiative examined the distribution of initiatives across the Defence enterprise related to wellbeing to better understand the strengths and opportunities for improvement within Defence's and DVA's Protecting Lifetime Wellbeing Framework.¹⁴⁸
179. The Protecting Lifetime Wellbeing Framework underpins the joint Data Sharing and Analytics Solution (DSAS) between Defence and DVA, and 'aims to formalise accountability for and improve the health, safety and wellbeing of ADF members and veterans at different phases through effective data collection and reporting'.¹⁴⁹
180. Wellbeing factors were developed to support the framework to provide a consistent basis through which to understand longitudinal wellbeing across Defence and DVA.¹⁵⁰
181. Defence carried out a gap analysis to compare its current state with the desired state. The report stated, 'Strengths are apparent within the transition phase, with a majority of initiatives understandably focused on being delivered within this phase of the lifecycle'.¹⁵¹
182. The report defines areas of strengths as 'where a Factor has a number of initiatives that provide a tangible, positive impact on veterans and active personnel wellbeing'.¹⁵²
183. Yet, as we highlight in section 11.4.1 of this chapter, Defence is unable to measure if these initiatives are, in fact, improving the wellbeing of serving and ex-serving members.

184. The report also focuses on the transition of members from service to civilian life and highlights that Defence efforts in responding to risk factors that contribute to suicide and suicidality are predominantly focused on this phase of service life.
185. There is limited focus on risk factors in service.

The draft evaluation of the Defence Mental Health and Wellbeing Strategy 2018–2023

186. Another example of Defence missing the mark can be found in the December 2023 draft Final Evaluation Project report for the Defence Mental Health and Wellbeing Strategy 2018–2023. It reported that:

After adjusting for age, suicide trends for ADF members show that serving ADF members have significantly lower rates of suicide death than the Australian general community ...

Defence permanent force members have significantly higher suicide literacy compared to the Australian adult population, potentially lower suicide stigma and higher intention to seek help if experiencing suicidal thoughts or behaviours.¹⁵³


187. We find these statements concerning for several reasons, particularly given that they were made after our Royal Commission had been underway for more than two years.
188. First, the age-adjusted ‘Australian general community’ is not the best group against which to compare serving members, who are, by definition, employed. Our analysis found that males serving in the permanent forces are 30% more likely to die by suicide than Australian employed males,¹⁵⁴ and males serving in the permanent forces in combat and security roles are twice as likely to die by suicide as Australian employed males.¹⁵⁵
189. Second, the draft report ignores the dozens of reviews that have found that military culture, mental health stigma and structural and cultural barriers to help seeking *are* significant issues within Defence. These statements seem to suggest that the opposite is true.
190. Third, the wording ‘potentially lower’ is confusing and unclear.
191. Fourth, without knowing whether ADF members actually do seek help if experiencing suicidal thoughts or behaviours (or simply have an ‘intention’ to) lessens the weight of such a statement.
192. Fifth, the findings on stigma and help seeking were based on the 2023 YourSay Workplace Experience survey, a Defence-wide survey of organisational culture and climate.¹⁵⁶ We have found limitations with this survey, which we discuss in Chapter 29, Use of data and research by Defence and DVA.

193. Finally, and perhaps most importantly, suicide rates among serving members simply cannot be divorced from, and should not be reported in isolation from, those of ex-serving members, since:
- exposure to stressors and negative experiences during service is cumulative and the effects may not be fully felt for some time, often after separation
 - context is everything: factors such as a sense of meaning and purpose, strong belonging to the group, stoicism and a strong military identity can be protective during service but can contribute to suicide risk after separation
 - the mode of separation, particularly whether it is voluntary or involuntary, is significantly associated with suicide risk; by definition, a serving member has not undergone separation.
194. We have gone to some lengths to unpack these statements from the December 2023 draft Final Evaluation Project report for the Defence Mental Health and Wellbeing Strategy 2018–2023 because taken together, one might be forgiven for assuming that there is ‘nothing to see here’, and no issue of suicide and suicidality in the Defence community. Concerningly, these statements seem to indicate that Defence is still wary of admitting that there is a problem.
195. To highlight the incongruity of Defence implying that stigma and lack of help-seeking are not issues for its members, we balance these statements against examples of recent reports and reviews that have expressed concerns about military cultural issues related to stigma and help-seeking.
- The Inspector-General of the Australian Defence Force in its 2021–22 annual report highlighted evidence from its inquiries that mental health conditions are underreported to Joint Health Command or the chain of command. Contributing to this is reluctance to seek help and mental health stigma.¹⁵⁷
 - The Productivity Commission’s 2019 report, *A Better Way to Support Veterans*, noted stigma associated with admitting a mental illness was one factor underpinning the reticence of members to report injury and illness.¹⁵⁸ In 2021, Dr Bernadette Boss, interim National Commissioner for Defence and Veteran Suicide Prevention, also highlighted issues with stigma and help-seeking in the ADF.¹⁵⁹
 - Defence’s own 2022 Behaviour Safety Review identified stigma as a challenge in managing mental health and wellbeing. It cited concerns regarding mental health and disclosures that were impacted by concerns about career consequences.¹⁶⁰
 - We also examine issues associated with stigma and help-seeking in Chapter 15, Promoting health and wellbeing among ADF members, Chapter 7, Culture and leadership, and the three chapters of Part 3, Misconduct, complaints and military justice.
196. It would be very concerning if these statements from the draft 2023 Final Evaluation report were used to inform strategy and risk management, without considering other evidence and examining the reasons for the contradictory findings.

Reports informing the next iteration of the Mental Health and Wellbeing Strategy

197. Defence commissioned three reports to determine ‘what the opportunities are’ in relation to the next iteration of the Mental health and Wellbeing Strategy.¹⁶¹ The purpose of the first of these reports was to ‘highlight the current state of mental health and wellbeing in Defence’.¹⁶²
198. The June 2023 presentation, ‘Foundation for the next Mental Health and Wellbeing Strategy’, to the Defence People Group Committee, drew on those three reports.¹⁶³ The presentation slide shown in Figure 11.1, drawing on the material presented in the first report, concluded that the current state of Defence’s response to the risks of military service ‘could be assessed as stable’ and stated that ‘focusing on the transition out of service could be an area for improvement’.¹⁶⁴

Figure 11.1 Presentation slide on responding to the risks of military service


**Summary Report One: Current State**

Responding to the risks of military service


“Defence recognises that to achieve its mission to Defend Australia and its national interests, ADF members are often put in harm’s way and as a result can be exposed to traumatic situations.”


Keywords related to this objective where statistics related to the cause or likelihood of suffering from mental ill-health include: Family, Suicide/suicidality, Alcohol or drug use, PTSD, Veteran, Lifetime wellbeing, Recruitment, Transition, Discharge, and Separate.

The review of this objective found that while there are some positive indicators:

**Lower suicide rate** in serving ADF population than the Australian population
(Sadler et al.)

Yet, improvement can be found in the following statistics:

**46% of ex-serving ADF members** who’d transitioned in the last five years **met diagnostic criteria for a mental disorder** in the previous 12 months
(Mental Health Prevalence and Pathways to Care Summary Report)

**3 in 4 of ex-serving ADF personnel** will meet criteria for a **mental disorder in their lifetime**
(Mental Health Prevalence and Pathways to Care Summary Report)

Thus, review of the current state of Defence’s response to the risks of military service found that through the current Strategy it could be assessed as stable. Focusing on the transition out of service could be an area for improvement.

Source: Foundation for the next Mental Health and Wellbeing Strategy Summary Presentation June 2023¹⁶⁵

199. The slide only mentions transition out of service as an area for improvement.¹⁶⁶ There is no reference to other areas of focus during serving life nor to any specific service-related risk factors.
200. It is concerning that in the face of sustained suicide rates for over 20 years, and many reviews pointing to issues within Defence that contribute to suicide and suicidality, the summary of the report could only state that Defence's response to the risks of military service ... could be considered 'stable'. Aside from it being hard to decipher what this statement means, the slide provides no indication that many tens of reviews suggest that Defence should be doing a lot more. From this perspective, perhaps 'stable' is not a good position for Defence to be in.
201. Defence strategy in relation to mental health and wellbeing has not sufficiently prioritised service-related risk factors. There should also be clear focus on identifying at-risk cohorts of serving members and managing the risks they are exposed to. Previous reviews have pointed to service-related risk factors. The Productivity Commission highlighted several in its report, *A Better Way to Support Veterans*:

In the context of organisational culture, it is interesting to note that a study looking at the mental health of police and emergency workers found 'poor workplace practices and culture ... to be as damaging to mental health as occupational trauma'¹⁶⁷ ...

For the veteran community, additional military-related risk factors include combat or other operational experience, disciplinary action, reduction in rank or medical employment classification status with loss of status and identity, separation from unit or service and difficulties with post-deployment adjustment.¹⁶⁸

202. Dr Boss identified in-service risk factors as including alcohol or drug misuse, physical health issues, and experiences of being bullied, harassed or sexually assaulted.¹⁶⁹
203. This Royal Commission has also identified a range of service-related risk factors for suicide and suicidality. Chapter 1, Understanding suicide, lists:
- stressors associated with the postings cycle and service life that contribute to separation from family, family disruption and relationship breakdown
 - bullying, harassment, discrimination, misogyny, military institutional abuse and military sexual violence (often referred to under the umbrella term 'unacceptable behaviour')
 - interaction with the military justice system
 - exposure to traumatic events
 - burnout
 - service-related injury and illness
 - the negative effects of military cultural values.

204. We did not see these risk factors reflected in the ‘Foundation for the next Defence Mental Health and Wellbeing Strategy’ presentation, nor were they reflected in the previous Mental Health and Wellbeing Strategy.¹⁷⁰
205. During our procedural fairness process, Defence put forward previous strategies, including the ADF Mental Health and Wellbeing Plan 2012–2015, that had objectives focused on identifying and responding to mental health risks associated with military service. Others were the 2018–2023 Mental Health and Wellbeing Strategy that built upon that plan and findings from previous reviews, and the Defence and Veterans’ Mental Health and Wellbeing Strategy 2024–2029 that recognised service-related risk factors.¹⁷¹
206. While these documents acknowledge in general terms the need to identify and respond to service-related risks, and outline activities needed to better understand these risks, they do not identify in detail what these risks are, beyond the fact that transition is a time of heightened risk. Years of health and wellbeing strategies should have evolved by now to identify those risks in granular detail and include them in documents related to risk management and strategy.
207. For example, the Defence and Veterans’ Mental Health and Wellbeing Strategy 2024–2029 states that ‘Defence and DVA have both been working to reduce the risk factors for suicide’.¹⁷² However, the narrative that follows focuses almost exclusively on DVA’s activities to improve transition supports.
208. Defence also referred to its partnerships with the World Health Organization Collaborating Centre for Research and Training in Suicide Prevention and the Australian Institute for Suicide Research and Prevention aimed at developing a research framework to assess service-related risk and protective factors for suicide. It also referred to its suicide prevention program and activities related to training and education, the suicide monitoring system and other programs associated with its suicide prevention program.¹⁷³
209. These are all positive efforts, and we commend them. However, the concern that we are highlighting in this section is that we have not observed any real evolution in Defence strategies over time. Where we would expect Defence to demonstrate what it has learnt from numerous reviews and our own interim report, and to update its language to include more specificity in service-related risk factors and how it intends to mitigate them, we have seen nothing of the sort.
210. The 2023 Foundation for the next Defence Mental Health and Wellbeing Strategy presentation is a relatively recent strategy document (from June 2023). Rather than acknowledging with courage and humility the now well-known service-related risk factors for suicide and suicidality, Defence instead retreated to its former position of suggesting that the only service-related risks are associated with transition.

211. Current approaches have not yielded effective outcomes over the past 20 years. Defence needs to radically shift its stance to acknowledge and target service-related risk factors. Defence must be more robust in its risk assessment and strategy development if it is to reduce suicide and suicidality among serving and ex-serving members.

It is unclear which strategy takes precedence and how they relate

212. Defence has many strategies that relate to the wellbeing of serving members; however, it is unclear how they relate to each other or to an overarching strategic plan. There are no measures to evaluate the progress of individual strategies or their final outcomes. It is not clear who is accountable for delivering them, especially at the level of individual accountability.

213. Defence strategies relevant to our terms of reference include:

- the ADF Health Strategy: Ready, Responsive, Resilient (2020–2033)¹⁷⁴
- the Defence Enterprise Culture Strategy¹⁷⁵
- the Defence Mental Health and Wellbeing Strategy 2018–2023 and the Foundation for the next Mental Health and Wellbeing Strategy¹⁷⁶
- the Defence Work, Health and Safety Strategy 2023–2028¹⁷⁷
- the Defence Strategic Workforce Plan 2021–2040, Interim workforce plan 2024¹⁷⁸
- the draft Defence and Veteran Mental Health and Wellbeing Strategy 2024–2029.¹⁷⁹

214. The National Defence Strategy was released on 18 April 2024. This strategy states:

Defence is also prioritising programs to prevent suicide and is positioned to respond with urgency to the Government's accepted recommendations from the Royal Commission into Defence and Veteran Suicide.¹⁸⁰

215. We appreciate the acknowledgement of our work. However, to date, there has been a conspicuous lack of clear focus on serving and ex-serving member suicide and suicidality in Defence's strategic planning. Where member health and wellbeing and/or suicide and suicidality are recognised in strategic documents, there are no measures of progress by which success would be evaluated.

216. The 2023 policy, How One Defence Works, aims to align Defence's operating model with findings from the 2023 National Defence Strategic Review, and recognises:

Our People are intrinsic to the One Defence Operating Model. Defending Australia and its national interests in an era marked by strategic complexity presents significant challenges. Defence's ability to respond is contingent on the expertise, resilience and adaptability of our people.¹⁸¹

217. How One Defence Works details the capabilities Defence needs of its members to achieve strategic goals and objectives. However, there is no reference to how Defence, in turn, will support the health and wellbeing of its members. Furthermore, none of these strategies include measures of success, which makes it impossible to assess whether objectives are achieved.

218. Through the procedural fairness process, Defence advised of efforts to better integrate performance, risk and planning, saying:

Defence is pursuing additional measures to achieve an integrated performance, risk and planning approach at the enterprise level. Planning is now required across Groups and Services to address Corporate Plan and Defence Priority Statement requirements, including risk to achievement. Further maturity in this integrated approach, which includes wellbeing of our people, is being progressed following the release of the 2024 National Defence Strategy.¹⁸²

219. We can only say we sincerely hope this is the case.

Recommendation 39: Address risk factors for suicide and suicidality and report on progress as part of enterprise-level risk management

Defence should address in-service risk factors for suicide and suicidality as part of the reporting processes related to enterprise risk management and the development of mental health and wellbeing strategy by:

- (a) identifying in-service risk factors to be reported (including, but not limited to, the risk factors for suicide and suicidality related to Australian Defence Force service identified in Chapter 1, Understanding suicide)
- (b) developing outcomes-based measures against these risk factors
- (c) developing risk controls and measures of control effectiveness.

Enterprise risk management must be informed by a contemporary assessment of hazards related to the health and wellbeing of Defence personnel and should inform delivery of the joint Mental Health and Wellbeing Strategy 2024–2028.

11.5 Supporting good governance from unit to enterprise

220. The Australian National Audit Office (ANAO) highlights the importance of culture in supporting effective governance, including risk management:

Creating a positive risk culture is not a standalone activity, it is created through actions on a variety of fronts. A positive risk culture is essential to effective risk management, which in turn is essential for organisational success. An entity's risk management framework must support a culture where risk is managed and communicated across all levels of the entity and individuals are encouraged to adopt positive risk behaviours ... The culture should encourage bad news to be escalated, without fear of reprisal.¹⁸³

221. Chapter 7, Culture and leadership, discusses how organisational culture affects governance and either supports or diminishes leaders' ability to identify and respond to risks. Chapter 7 highlights several matters related to organisational culture that are relevant to good governance.

- The 'code of silence', an informal military norm by which it can be seen as disloyal to the team to speak up, acts as a strong barrier to reporting unacceptable behaviour, escalating a complaint or notifying about a risk.¹⁸⁴
- Cultural norms related to stoicism, self-sacrifice and self-reliance can reinforce stigma around seeking help and can lead to members choosing not to disclose injury or illness, and avoiding or delaying medical treatment until the issue reaches crisis point.¹⁸⁵
- The command-and-control leadership style and the hierarchy of commissioned and non-commissioned officers can influence members' willingness to complain or to escalate a risk or an issue.¹⁸⁶
- The Defence's Safety Behaviour Review reported that while Defence roles 'reference accountability for safety decision-making', leaders at all levels 'often failed to display consistent actions, communications, and training regarding safety'.¹⁸⁷

222. In this section, we consider how ADF culture influences how, when and what information is provided to decision-makers, particular regarding the escalation of risks and issues. We also consider the challenges of busy unit managers and commanding officers who are often under a lot of stress and have significant reporting requirements. Their challenges are increased by the 'hollowing out' of the ADF workforce.

11.5.1 Risk and culture

223. The Defence Risk Appetite Statement, signed by the Secretary and the Associate Secretary of the Department of Defence, and the Chief of Defence Force in September 2023, describes the ‘low willingness to accept risks that have the potential to result in harm to Defence personnel’.¹⁸⁸ This is significant statement; however, a statement of intent does not necessarily equate to cultural, structural and behavioural change.

224. Issues associated with Defence’s risk management culture and a reluctance to raise risks in briefings or verbally are not new; they have been raised in a number of reviews internal and external to Defence.

225. In 2018, Defence did a ‘deep dive’ review of its Cultural Evaluation Framework. Many of its focus group participants revealed that they felt uncomfortable to own a mistake and accept accountability, fearing being ‘thrown under the bus’.¹⁸⁹ The report stated:

the extent to which this issue was raised across the interviews, coupled with the comments that decision making has been ‘pulled up’ [putting decisions in the hands of senior leaders], is strongly suggestive of a cultural issue around risk, and not just an issue of individuals with low risk thresholds.¹⁹⁰

226. The *First Principles Review: Creating One Defence* also highlighted Defence’s change-averse culture and how this influenced its implementation of recommendations. It gave examples where Defence had ‘added veneers of process, papered over the concerns of reviewers and the findings of auditors, and avoided fixing the underlying problems’.¹⁹¹

227. In April 2023, Defence revised its Enterprise Committee Governance Framework, incorporating eight principles developed to support best-practice decision-making across the Defence Enterprise Committees.¹⁹² These included a preference to ‘resolve any issues early and at the lowest level possible’.¹⁹³

228. Professor Rufus Black, a member of the Afghanistan Inquiry Implementation Oversight Panel, made these observations about how organisational culture influences risk management:

I note too in that [the] health and safety context, the important cultural tasks of ensuring that you establish a culture of organisational learning, so that failure and accountability doesn’t necessarily ... equal ‘blame’ all the time. If it leads just to blame and destructive consequences for people, then reporting doesn’t happen and culture doesn’t change. Accountability in that sense is actually about owning a problem and owning the need to create change at whatever level.¹⁹⁴

229. The 2023 *Defence Mental Health and Wellbeing Strategy and Continuous Improvement Framework Evaluation*, ‘Developmental Evaluation – Preliminary Findings Report’ noted the need for a stronger focus on risks that are exacerbated by ADF service.¹⁹⁵

230. Organisational culture affects risk reporting and compliance and the senior leaders of any large and diverse organisation, such as Defence, have a significant influence on culture, both in setting the tone and creating an environment where it is safe to report risk.

11.5.2 Information needs to flow to decision-makers as intended

231. The ANAO highlights the importance of good information getting to the right people to support good governance:

Information and analysis support the decision-making process, making it possible for officials to make well-informed, sound and defensible decisions. Information and analysis also inform entities about how best to effectively design programs and strategies; allocate scarce resources to mitigate program and service delivery risks; and provide assurance that key requirements are being met.¹⁹⁶

232. Accessible and accurate briefings are critical to good governance. Briefings through governance structures seek to ensure that the right information gets to the right people at the right time to inform decision-making. Associate Secretary of Defence Matthew Yannopoulos, agreed that ‘top-level decision-making and a strong strategic centre can only function effectively if armed with relevant and comprehensive information’.¹⁹⁷ He also agreed that the enterprise committee structure, and ‘the strategic centre proactively reaching down to ensure that it has all the relevant and comprehensive information’ were two ways of achieving that.¹⁹⁸

233. However, reviews have identified cultural issues with briefings to senior leaders and committees that are conducted in a way that erodes accountability and disempowers less senior staff.¹⁹⁹

234. The 2022 Proximity Review found that briefings to Defence Committees were failing to account for risk and that committee participants were not raising risks during discussions or guiding business lines on appropriate risk considerations.²⁰⁰

235. When asked by Counsel Assisting how senior leaders can be sure that their staff have implemented programs of work, Mr Yannopoulos said that program owners were entrusted with managing the work program. He said it was not something he would regularly follow up on an individual basis, stating:

if an area is owned by someone and they have a program managing it, we won’t necessarily go and look inside it to see if it’s following through. We rely on our governance system to do that.²⁰¹

236. The Enterprise Committee Governance Framework includes brief guidance on ‘escalation thresholds’ that are guided by the preference that ‘committee matters or decisions [be] resolved at the lowest tier level, to reduce the impact on committees and their membership.’²⁰²

237. We identified examples where senior leaders and governance committees were in the dark about risks and reviews that concerned their area of management. For example, the Associate Secretary said that until the information was requested by this Royal Commission, he was not aware of the Mental Stress Review and the Body Stress Review, despite them being pertinent to managing health and wellbeing of Defence personnel, and within his line management.²⁰³ The Associate Secretary agreed that he would have expected to have been made aware of the findings of both reviews.²⁰⁴
238. When asked about the steps the Workplace Health and Safety Board took to action the findings of the Mental Stress Review, Mr Yannopoulos agreed that mental stress was a critical enterprise issue.²⁰⁵ He said, 'It concerns me that we had a report that looks like this and there's no document over the top of it that puts it in context and [says] what we're going to do with it.'²⁰⁶
239. The Workplace Health and Safety Board did not notify him of the Mental Stress Review. This is particularly concerning, given that it had been initiated as part of Defence's workplace health and safety framework and had made some concerning findings. Mr Yannopoulos also said he was not aware of the project completion report of the Work Health and Safety Focus Area: Body Stressing project from September 2021.²⁰⁷ We discuss this in more detail in Chapter 13, Oversight of Defence workplace health and safety. Mr Yannopoulos agreed that his lack of awareness was a governance blind spot.²⁰⁸
240. The briefing to the Enterprise Business Committee on the 2022 Baseline Review into the Defence Accountability Framework focused on work already underway or future opportunities. It did not discuss the significant problems identified in the Baseline Review, although the report was attached to the briefing.²⁰⁹
241. Mr Yannopoulos gave evidence to the effect that Defence's senior executive do not have strong organisation-wide visibility of psychosocial risks and risks relating to suicide.²¹⁰ He agreed that the effectiveness of enterprise-wide systems is important in suicide prevention, because enterprise committees inform senior leaders of risk across the organisation.²¹¹ He also agreed that if systems are not working, enterprise-level decisions cannot be based on accurate enterprise-wide information.²¹²
242. A November 2023 paper to the Enterprise Business Committee indicated a number of issues with briefings to committees. They had been identified by the Enterprise Transformation and Governance Division (ETG) based on discussions between the ETG and committee members of the Enterprise Business Committee in the preceding 12 months.
243. The paper identified the need for 'greater transparency on how each area contributes to delivering outcomes and response options to government, and the level of performance and risks across those activities.'²¹³ The paper also highlighted the need for 'assessment to include the consequences and impact across the enterprise, which are often missing from our current approach.'²¹⁴

244. In Chapter 10, The ADF military justice system, we highlight various related governance issues:

- Then Vice Admiral Johnston conceded that a breakdown in governance had occurred where a Tier 1 committee (the Defence Committee) directed that a piece of work be done, and a Tier 3 committee (the Military Justice Steering Group) could not do it for want of resources. This issue was never communicated back to the Defence Committee for resolution.²¹⁵
- In 2022, the Director of the Directorate of Inquiries in the Office of the Inspector-General of the ADF identified concerns about gross errors made in departmental inquiries that should have been picked up by legal officers during reviews of those inquiry reports.²¹⁶ Then Vice Admiral David Johnston said he was unaware of those concerns until March 2024. He acknowledged that they were significant concerns that should have been brought to his attention and said this had been a breakdown in governance processes.²¹⁷
- The reporting from the Military Justice Steering Committee to the Chiefs of Services Committee is at times unclear. At no point, in the papers presented to the Chiefs of Services Committee, is it clear, for example, that its risk framework was delayed by years.²¹⁸

245. For an organisation as large as Defence, flows of information must be clear and accurate to support effective decision-making. This is critical.

246. Defence advised us through the procedural fairness process that the Parliamentary Document Management System (PDMS) is being rolled out in 2024 to improve record-keeping of committee decisions and Defence Enterprise Committee workflows.²¹⁹ Defence has told us that PDMS will improve the recording of internal decision-making, and transparency of actions and accountability.²²⁰ Although this is a positive step, the introduction of PDMS will not fix any issues associated with the quality of information provided to committees, or people's judgments about what information should be presented when escalating a risk. While systems are important, people always play the more significant role and organisational culture influences them.

11.5.3 Issues with record-keeping, data entry and data management are entrenched

247. There are many issues that influence the quality and comprehensiveness of data collected, stored, analysed and used within Defence and these are covered in detail in Chapter 29, Use of data and research by Defence and DVA. They include poor record-keeping practices within Defence that affect multiple systems and datasets. These issues are highly relevant to a discussion of Defence governance as compliance reporting and record-keeping are essential inputs to leaders making decisions about risk assessment and other domains of governance.

248. For Defence's governance system to work effectively, its serving members and other employees must engage with its processes.

249. The 2023 Ombudsman report ‘Defending Fairness: Does Defence Handle Unacceptable Behaviour Complaints Effectively?’ highlighted issues with data entry and record-keeping at the unit level. The report stated:

The personnel we interviewed understood the need for reporting but saw the multiple reporting systems as administratively burdensome ...

Complaint records were incomplete and lacking documentation of key steps in the process. We could not determine whether this is because the process was not followed in such instances or because records were not being kept in an interrogable form.²²¹

250. An evaluation of the Mental Health and Wellbeing Strategy noted:

much of the available data was ‘dirty’, inconsistent and lacked coordination within and between datasets. A full project rescoping was required because the original assumptions underpinning the agreed program-of-work no longer held, previously identified data was not fit for purpose and the brief was not implementable.²²²

251. The evaluation also observed that many mental health programs, initiatives and activities use similar data collection tools, implying duplication of process, saying that despite this:

most tools are delivered independently, not shared and miss the opportunity for systematic use across personnel journeys in Defence.²²³

252. In 2023, Major General Wade Stothart DSC AM CSC, Chair of the Military Justice Steering Group, gave evidence that the group remained dissatisfied with the quality of reports and record-keeping, saying:

it is an area of concern for the [Military Justice Steering Group] and myself, as the Chair, that the discipline systems, statistics and data [be] better recorded, better kept, better reported and therefore better analysed. Our administrative system, particularly as it pertains to sanctions and other aspects of that administrative system, is not as well recorded, reported, and therefore the ability to conduct the analysis on it is not as good as we would like.²²⁴

253. In Chapter 10, The ADF military justice system, we note that the Inspector-General of the ADF’s military justice performance audits have consistently reported poor record-keeping and data entry practices. In 2019, the Inspector-General reviewed themes from the 2016–17 and 2018–19 financial years and presented them to the Military Justice Steering Group. The Inspector-General noted that ‘failure to maintain accurate record-keeping – particularly in relation to unacceptable behaviour – is a common theme we identify on military justice audits’.²²⁵

Governance compliance is burdensome to commanding officers and unit managers

254. We highlight in several chapters across this report that staffing deficiencies caused by high separation rates, a failure to meet recruitment targets, and medical-related unavailability have resulted in a ‘hollowing’ of the Defence workforce.²²⁶ The increased pressure that results from this can lead to exhaustion and burnout for the Army workforce.²²⁷
255. This is important to understand as context for some of the challenges we have outlined in this chapter. Governance processes associated with risk management and performance reporting require attention and input from unit managers and commanding officers. However, as highlighted in the previous section, record-keeping and data processes can be administratively burdensome.²²⁸
256. It would not be surprising if the pressures of operational duties combined with workforce shortages contribute to the issues we have observed in the effective administration of governance processes (particularly to do with risk escalation and performance reporting).
257. Defence’s own audits have identified competing pressures as a contributing factor to poor reporting and record-keeping practices. Select Strategic Issues Management delivered the *Analysis of IGADF Military Justice Performance Audit Report* in 2022. It reviewed 63 reports from 1 January 2021 to 30 September 2022.²²⁹
258. This analysis highlighted various issues, including:
- problems with record-keeping practices and data management ²³⁰
 - that reference manuals were hard to understand, using highly technical, legalistic language, and updates were not communicated in a timely manner ²³¹
 - multiple record-keeping systems were being used to record single incidents, which wasted time ²³²
 - poor record-keeping practices were a widespread issue and constituted about half of all recommendations about both the disciplinary and administrative streams of the ADF military justice system.²³³
259. The March 2023 minutes of the Air Command Safety Board gave some insight into compliance challenges for busy commanding offices. Representatives said that ‘excessive governance [requirements were] placing burdens on the workforce’ and expressed frustration with ‘red tape and bureaucracy’.²³⁴

260. A briefing to the Enterprise Business Committee in November 2023 provided an overview of themes gleaned by engaging with committee members. These findings included:

Removing duplication in reporting is key to reducing burden on the workforce. Where possible, existing assessments and reporting should be leveraged for multiple purposes, duplication stopped and functions rationalised.²³⁵

261. To address poor reporting, data entry and record-keeping practices, it is important to understand their cause. This means considering the experiences and views of unit managers and commanding officers, who are essential to the process but who bear the burden of reporting and governance compliance record-keeping and briefing.

Streamlining processes to improve governance culture

262. It is important to listen to those who are responsible for feeding information upwards to understand and address barriers to good governance from managers' perspectives.

263. We have been conscious of these perspectives when making our recommendations. Improving accountability and transparency in addressing member health and wellbeing and mitigating service-related risk factors for suicide and suicidality is essential, as is a culture of continuous improvement. However, we are also aware of the administrative burden that increased reporting and accountability may create.

264. There are various ways that governance requirements can be streamlined to reduce administrative burdens on managers.²³⁶ Defence advised by notice that its new record-keeping and data management system (CASE) is expected to help reduce poor record-keeping in the military justice system.²³⁷ CASE seeks to combine disparate systems into one, capturing various datasets, including those across the military justice system, for collective analysis.²³⁸ However, it cannot resolve poor record-keeping practices and is not expected to resolve all record-keeping issues. Defence told us:

Effective record-keeping using CASE will remain reliant on accurate information input across all personnel transacting in the system across all Defence business units.²³⁹

265. Defence noted it will be unable to assess the nature and scope of ongoing record-keeping issues until CASE has been rolled out, starting in mid-2024.²⁴⁰

266. Defence has told us that the primary method for fixing poor service-level record-keeping is to monitor the timely implementation of performance audits recommendations made by the Inspector-General of the ADF. Also, if necessary, it offers corrective training, mentoring, professional development sessions and legal assistance.²⁴¹ If deficiencies persist, the sub-standard performance can be managed through performance appraisal reporting.²⁴²

267. These strategies are unlikely to remove the cause of poor compliance with record-keeping and reporting requirements, however. They do not seek to understand or remove the obstacles to good record-keeping from unit managers and commanding officers. This would necessarily include thinking through how to reduce the administrative burden while ensuring that regulatory needs are met.
268. Issues with record-keeping compliance also affect work health and safety and other risk-management domains within Defence. These are discussed in Chapter 13, Oversight of Defence workplace health and safety.
269. We encourage Defence to explore different ways of improving processes. These must tackle the root cause of compliance issues, including the burden placed on busy commanders, and help streamline record-keeping without the need for significant IT investment.
270. There are various ways by which governance requirements can be streamlined, reducing the administrative burdens on managers. These include:
- Lean Thinking, which seeks to reduce waste and enhance business performance by improving workflow
 - the Kaizen Methodology, which focuses on making small improvements in large numbers and continually involving all employees, leading to better relationships between managers and employees
 - the Six-Sigma Methodology, which aims to identify and remove errors, defects, and causes of failure in business processes by concentrating on outputs
 - the Super Methodology, which aims to improve business processes, including by process re-engineering and benchmarking.²⁴³
271. To build a culture of accountability that supports good governance, Defence needs to lift the shared understanding of risk management and performance reporting across the services, while also streamlining governance processes and reducing the administrative burden associated with them.

Recommendation 40: Improve governance mechanisms from the unit level to the enterprise level

In order to identify and address barriers to effective governance from the unit level to the enterprise level, Defence should:

- (a) review all internal and external governance reporting mechanisms
- (b) identify root causes of non-compliance with required reporting
- (c) identify duplicative reporting information and processes
- (d) draw on process-improvement methodologies (for example, Lean Thinking) to reduce the administrative burden of reporting and governance compliance across Defence
- (e) improve governance, performance-reporting and data literacy at unit, service and enterprise level via training and/or embedding coaching.

11.6 An endless cycle of reviews

272. Defence's governance, risk management and strategy processes have been scrutinised by numerous reviews into the health and wellbeing of serving and ex-serving members over the past 20 years.
273. In their 2023 report, *Mapping Service and Transition to Self-harm and Suicide*, Professor Ben Wadham and others noted that there had been around '35 inquiries since 1970 on and by the ADF on military culture, military justice, complaints handling, institutional abuse and women's participation'. They argued that 'the ADF ha[d] not addressed the recommendations in these inquiries effectively'.²⁴⁴
274. Table 11.1 lists nine recent reviews of ADF member and Defence employee mental health that we reference in this chapter.

Table 11.1 Recent reviews of mental health

Review	Context
The Dunt Review (2009) of Mental Health Care in the ADF ²⁴⁵	Initiated by then Ministers for Defence Science and Personnel, and Veterans' Affairs, the Dunt Review reviewed the extent to which mental health needs were being met and identified barriers to accessing support. ²⁴⁶
The 2014 evaluation of the Dunt Review Implementation by Commuio ²⁴⁷	The evaluation concluded that the recommendations had been effectively implemented; however, it noted that 'inconsistency in program implementation and delivery of services was a recurring theme throughout the evaluation'. ²⁴⁸
The 2016 Kinghorne Review: <i>Suicide and Mental Health in the ADF – what are we missing?</i> was commissioned by then Chief of the Defence Forces in 2015 ²⁴⁹	The review report noted that 'despite the significant time, money and other resources expended by Defence on mental health in the past ten or more years, serving members have continued to take their own lives'. ²⁵⁰ The review sought to examine all aspects of ADF management of suicide and consider the journey of service life from recruitment to transition.
The 2017 National Mental Health Commission Review into Suicide and Self-harm Prevention Services available to current and former serving ADF members and their families ²⁵¹	Announced in 2016 by the then Prime Minister, then Minister for Veterans' Affairs and Defence Personnel and then Minister for Health and Aged Care, the review considered the progress that had been made since the 2009 Dunt Review and raised concerns that themes of previous reviews had been consistent in there being a lack of evaluation of training programs and services. ²⁵²
The 2019 Productivity Commission report, <i>A Better Way to Support Veterans</i> ²⁵³	The report noted a lack of integration between DVA and Defence led to 'perverse incentives' that affected members' wellbeing, as well as gaps in services and poor accountability. In relation to the Department of Defence, the Productivity Commission found that Defence could focus more on prevention and improve its compliance with respect to notifying Comcare of incidents. ²⁵⁴
The 2020 Axiom Audit – Work Health and Safety Assurance Program ²⁵⁵	Initiated at the request of Defence's Enterprise Business Committee, the Axiom Audit reviewed the effectiveness of WHS audit programs across the whole of Defence. ²⁵⁶
The 2021 Preliminary Interim Report of the interim National Commissioner for Defence and Veteran Suicide Prevention ²⁵⁷	The report provided findings and recommendations to address risk, enhance protective factors and address systemic issues relevant to ADF member and veteran deaths by suicide. ²⁵⁸
The 2022 Safety Behaviour Review ²⁵⁹	The review was instigated by Defence in 2021 to establish a baseline understanding of their safety behaviour and culture across the enterprise. ²⁶⁰ In collaboration with KPMG and Sentis, the review occurred over four phases to identify benchmarks for performance against safety policies and procedures and associated behaviours. ²⁶¹
The 2022 Mental Stress Review ²⁶²	This review was born out of a proactive focus on workplace health and safety hazard areas by the Defence WHS Board.

275. Through our procedural fairness process, Defence advised that they have:

conscientiously and continuously engaged with the various recommendations [of the] 25 reviews since the early 2000s.²⁶³

276. Defence provided a response to a Notice to Give that documented many actions and initiatives to address suicide rates it had instigated in response to the reviews and information available to it.²⁶⁴

277. While we acknowledge these efforts, we emphasise again that there has been limited and slow progress in delivering against the specific objectives and broader intent of these reviews. Previous reviews have identified that Defence's approach to implementing recommendations is to focus on activity (that is, outputs – what was done) instead of effectiveness (that is, outcomes – whether it worked).²⁶⁵

278. The interim National Commissioner for Defence and Veteran Suicide Prevention, Dr Boss, highlighted the lack of progress from more than 21 previous reviews in her 2021 Preliminary Interim Report (the Boss Report). Despite more than 335 recommendations, she said she had repeatedly heard that the issues identified had not yet been adequately addressed.²⁶⁶ Dr Boss stated:

I must stress that action cannot be delayed until the conclusion of the Royal Commission. To save lives, the Australian Government must act with urgency.²⁶⁷

279. In response to a question about inaction on Boss Report recommendations, Secretary for Defence Greg Moriarty said he was aware of the need for urgency for action.²⁶⁸ He stated:

I am aware that the Government hasn't formally responded, but I am also aware that the Government directed us to pursue some initiatives that were included in Dr Boss's report and that – and some of that work has been done and some of it is ongoing.²⁶⁹

280. In a response to the Minister for Veterans' Affairs and Defence Personnel, Defence committed to evaluate a proposal to develop a training course for all ADF members immediately prior to their discharge; however, this is the only formal indicator we have of the government directing action.²⁷⁰

281. Dr Boss could not have stated more clearly how urgent action is needed to save lives; however, we are yet to see in Defence a strong sense of urgency in implementing Dr Boss's recommendations, or those of other reviews.

282. During the same procedural fairness process outlined above, the Commonwealth asserted that:

Defence has considered the INC [interim National Commissioner] recommendations and agrees with the overall intent of the recommendations. In closely examining all recommendations of the INC Report, Defence is continuing work to reduce suicide risk, and is keenly aware of the need to act on further opportunities to prevent suicide.²⁷¹

283. We welcome this statement; however, we remain concerned that agreeing with the intent of a recommendation is not the same as thorough, outcomes-based implementation of it. In the absence of a specific directive from the Australian Government, there is no external driver for implementing recommendations nor scrutiny of outcomes.

284. We have identified several themes related to Defence's implementation of recommendations of previous reviews, which we have found to be ineffective and underpinned by poor project management capability and poor governance.

- Defence focuses on activity (outputs) instead of effectiveness (outcomes and benefits).
- Defence takes a 'set and forget' approach to implementing recommendations.
- Accountability for reform outcomes is not clear.
- Implementation of recommendations is underpinned by weak project governance and capability.

285. We examine these themes in further detail in the following sections.

11.6.1 Improving project management capability and governance

Definitions:

Business as usual refers to day-to-day operations, ongoing processes and procedures that keep an organisation running smoothly.²⁷²

Portfolios, programs and projects deliver change, including cultural change, to an organisation's business operations environment.²⁷³

Projects involve the delivery of one or more products (for example a training program, policy document or evaluation report) to realise an outcome that contributes to achieving an organisation's strategy. They have defined start and end dates.²⁷⁴

Program management is the delivery of outcomes that contribute to achieving an organisation's strategy.²⁷⁵ Delivering on the implementation of this Royal Commission's recommendations, for example, would form a 'program'.

286. Many reviews over 13 years have raised concerns that Defence's project management practices are deficient when it comes to implementing recommendations and reforms. They have identified that Defence needs to ensure that projects have executive sponsorship (a senior leader with clear accountability for delivery and reporting), increase project management capability, and improve project governance and benefits monitoring.²⁷⁶ For instance:

- the Black Review found diffuse accountabilities for executive sponsorship of projects with several people responsible for one project or decisions, as well as limitations in workforce project management skills.²⁷⁷
- the 2017 National Mental Health Commission Review found a lack of clarity between project and business-as-usual outcomes and a general lack of evaluation and measurement of training programs and services.²⁷⁸
- the Evaluation of the Dunt Review Implementation Report also criticised the absence of clear distinction between project outcomes and business-as-usual outcomes, noting an absence of performance measures to support evaluation.²⁷⁹

287. Making reforms (which includes implementing review recommendations) should be construed as either undertaking a 'project' or a 'program of projects', depending on the scope. This is because reforms seek to achieve significant change within the business and require resources such as time, money and personnel. Reform initiatives have a defined start and end date.²⁸⁰

288. The key difference between business as usual and programs and projects is that business-as-usual activities are ongoing and repeated whereas programs and project activities are temporary, unique and higher risk. The resources and methods used to manage business-as-usual activities should be different from those used to manage projects.²⁸¹
289. The reviews listed in Table 11.1 identify that Defence tends to focus on activities (outputs) instead of effectiveness ('benefits realisation'), and in some cases, signs off on recommendations when the objective has not been clearly met. When an organisation has issues with accountability for outcomes, it signals a lack of capability in project management and project governance.
290. The effective delivery of previous recommendations seeking to mitigate risk factors for suicide and suicidality among serving and ex-serving members relies on Defence ensuring that the 'benefits' – that is, the outcomes – associated with those recommendations are realised.
291. Defence informed us of activities underway that seek to promote efficiency and effectiveness in the projects it is managing. This includes a Program Management Centre of Expertise and Program Management Function that has produced new manuals, training materials and guidance for the functions of program management offices.²⁸² We discuss these in more detail in section 11.7.
292. We commend these efforts; however, are unable to comment on their effectiveness. If they improve Defence's project management maturity, they will have been a success. We describe what we mean by that in the sections that follow.

Executive sponsorship and project management capability

293. A number of reviews have called for more investment in project management capability and a stronger executive sponsorship of projects and programs. It is well established across project management literature that executive sponsorship, including clear accountability, is foundational to project and program success.
294. An 'executive sponsor' is defined as:
- [t]he single individual with overall responsibility for ensuring that a project meets its objectives and delivers the projected benefits. This individual should ensure that the project maintains its business focus, that it has clear authority and that the work, including risks, is actively managed. The executive is the chair of the project board.²⁸³
295. As far back as 2011, the Black Review into Defence governance and accountability identified that both military and civilian personnel lacked skills in capability development, project costing and the development of strategic policy.²⁸⁴

296. The 2017 National Mental Health Commission Review into services available to serving and ex-serving members and their families highlighted limitations in implementation and program management oversight.²⁸⁵

297. The 2022 Closure Report for the Defence Transformation Strategy acknowledged that over the course of the implementation of the strategy:

Many activities identified lack of senior sponsorship as a risk to the activity success. Without senior leaders having a clear and enforceable accountability for delivery and for reporting, the effectiveness of activity delivery and the quality of Enterprise Business Committee reports relied on for decision making were compromised.²⁸⁶

298. The closure report found that program management capability needed to be improved as expertise in program management was ‘unevenly held across the enterprise’.²⁸⁷ It stated:

Activity-level program management performance and change management capability will significantly increase effectiveness of not only priority reform delivery but also oversight and prioritisation. This capability uplift may occur in a number of ways, including as a requirement for inclusion in the Enterprise Priority Statement; through executive mandate; through Defence Transformation Office funded capability uplift or through more mature and embedded program management and change management systems.²⁸⁸

299. We agree with the recommendations from this report. We note the importance of upskilling project officers and project managers, as well as executive sponsors, and informing them of their roles and obligations in having project oversight.

300. Defence stated in our procedural fairness process that the implementation of the Dunt Review had executive sponsorship within Defence. The Mental Health, Psychology and Rehabilitation Branch was created in Joint Health Command in response to the Dunt Review and this branch oversaw the implementation of the recommendations. Defence pointed to the fact that a 2014 evaluation of the Dunt Review found that:

The recommendations of the review were implemented effectively, but there was inconsistency in the implementation and the delivery of services.²⁸⁹

301. However, it is unclear what the measure of effectiveness was, given that the review itself noted that outcomes associated with implemented recommendations were not well measured and that programs were not being utilised to their fullest extent.²⁹⁰ In other words, it is not clear that implementation of the Dunt Review recommendations actually achieved what was intended.

302. Defence has contested that a lack of executive sponsorship for some projects points to any shortcomings in program/project management, advising that:

Accountabilities are a component of Defence's organisational decision-making system and not attributed to program / project management practices.

303. This statement does not perhaps illustrate a complete understanding of project management principles and the critical role of executive sponsorship in ensuring accountability. Executive accountability for project delivery, including benefits realisation, is foundational to project success.²⁹¹ Accountability for delivery applies to both business-as-usual and organisational decision-making systems, as well as to project management.²⁹² Executive sponsors of projects should be accountable for delivery and champion the project throughout. They should navigate the various risks and help overcome barriers to implementation.²⁹³
304. Executive sponsorship is important and should be understood as a program and project management practice, distinct from Defence's organisational decision-making system, which applies to business as usual.

Project governance – a 'set and forget' approach to implementation

305. In 2021, the Australian National Audit Office (ANAO) released an 'Implementation of Recommendations' edition of its Audit Insights series, which drew on examples from the Auditor-General's previous audits across government departments.²⁹⁴
306. There are several takeaways from this document. They indicate the ANAO's expectations for governance arrangements related to responding to, monitoring and implementing recommendations, and were directed to large organisations in the Australian Government sector, such as Defence. The ANAO stated:
- that successful implementation of recommendations requires fit-for-purpose implementation plans that:
 - identify the intent of the recommendations and associated actions
 - set clear responsibilities and timeframes for addressing required actions
 - establish measures of success and/or outcomes to be realised²⁹⁵
 - that entities that are effective at implementing recommendations in full have processes to provide assurance that this has occurred and undertake quality-assurance processes before determining that a recommendation has been implemented and can be considered closed.²⁹⁶
307. Successive reviews have drawn attention to Defence's 'set and forget' approach to implementing recommendations. Chapter 7, Culture and leadership, refers to a number of reviews into Defence culture for which recommendations were considered to have been implemented based on Defence's 'activity', but that had limited measures of the effectiveness of those activities.²⁹⁷

308. The 2011 Black Review into Defence Governance and Accountability Framework identified a lack of individual accountability for projects and timeframes.²⁹⁸

309. The review stated:

Defence has commenced work several times in the past to resolve issues raised through formal review and recommendation. Our interviews revealed a common perception that such work has rarely gained the traction required once the immediacy of the issue that has driven a particular review has disappeared and the dedicated review team has been disbanded.²⁹⁹

310. A 2011 Australian Defence Force Personal Conduct Review report noted that the ADF tends to address recommendations by changing administrative processes and procedures. The report concluded that the usual response was procedural, resulting in a table of recommendations, each of which was individually implemented over time.³⁰⁰ The report found this was not a reliable strategy for achieving cultural change.

311. Eleven years later, the 2022 Proximity Review into Defence governance and accountability similarly found that Defence tended to only partially implement reforms. The review said that Defence needed to change its self-perception of change being too difficult. It cautioned:

The continuing cycle of conduct a review and then partial or limited implementation of the outcomes reinforces a culture that change in Defence is too difficult and cannot happen. This needs to change or the organisation will continue to stagnate and never reach its full potential or deliver its full capability.³⁰¹

312. Associate Secretary of Defence Matthew Yannopoulos gave evidence that recommendations may be deemed 'closed' if there is still work to be done, so long as it is clear who has the accountability to ensure that action is completed.³⁰² This can occur without them assessing whether the objective has been achieved, or benefits realised.

313. We urge Defence to consider fully the findings and recommendations of this report before acquitting activities or absorbing efforts into business-as-usual functions. This is particularly so in light of lessons learned from successive reviews and best-practice guidance from the ANAO, which we have highlighted throughout this section.

314. The reforms recommended in these various reviews relate to issues, risks and hazards that affect serving and ex-serving members' wellbeing, including some directly known to increase suicide risk. The significance of the problems they seek to address means that implementation activities need constant monitoring by Defence and their effectiveness assured. Ticking off an action on a status report as complete does not translate to harm reduction.

11.7 Recent progress by Defence to improve governance and accountability

315. As highlighted in section 11.6, reviews over a number of years have consistently raised concerns about Defence's project management practices in implementing recommendations and reforms. They highlight the need to increase executive sponsorship of projects, and improve project management capability, project governance practices, and benefits monitoring.³⁰³
316. During the procedural fairness process, Defence recognised that:
- the full implementation of previous reviews has been challenging. Defence recognises the substantial number of reviews that have occurred over the past two decades, the frequency with which they have occurred and the requirement for Defence to remain responsive to the Government's direction and strategic priorities. This has resulted in the implementation programs for some reviews being short-lived or being overtaken by the next review, and the recommendations from these reviews not always being fully implemented or resolved before another review commenced, rather than due to poor project/program management practices.³⁰⁴
317. We acknowledge this challenging context but highlight that the successive reviews have occurred precisely because of a lack of progress and in consideration of the urgency and seriousness of the issues. Serving and ex-serving member suicide and suicidality is a national tragedy and a source of shame. Defence's lack of progress has warranted scrutiny and accountability, and it is this that has resulted in frequent reviews.
318. We disagree with Defence's view that its programs being short-lived and sometimes incomplete is because of the review cycle rather than due to any poor project management practices. We have demonstrated, and Defence senior leaders have agreed, that Defence has consistently focused on measuring activity, rather than outcomes and benefits.³⁰⁵ We have also highlighted examples of breakdowns in governance processes regarding the escalation of issues.³⁰⁶
319. Defence has made efforts to improve project management practices through establishing a Benefits Management Framework and project or program management offices (PMOs).
320. In August 2021, the Enterprise Business Committee endorsed the Benefits Management Framework and associated toolkit, with a benefit realisation plan intended to follow.³⁰⁷ This was in response to 'the critical need for an enterprise strategy for benefits realisation management to have a clear, rigorous and transparent approach to qualifying benefits in delivering reform'.³⁰⁸
321. Defence established the Joint Health Command PMO in 2021 to oversee how programs and projects are governed and delivered in line with the ADF health strategy.³⁰⁹ This includes overseeing benefits management and measurement.³¹⁰

322. In August 2022, Defence established the Strategic Project Management Office to manage the delivery recommendations from our interim report.³¹¹ The Implementation and Reform Program will apply the Axelos Managing Successful Programmes methodology to its program design and the development of governance, oversight, roles and responsibilities, monitoring, reporting and assurance. The plan notes the importance of measuring performance and managing benefit realisation.³¹²
323. In October 2023, Defence established the Mental Health and Wellbeing PMO whose role it is to coordinate stakeholder engagement across Defence and to ensure our recommendations, along with mental health and wellbeing policy, programs and initiatives, are delivered effectively.³¹³
324. Our review of the documents relating to these PMOs and the Benefits Management Framework showed that these functions are being established based on good practice and international methodologies. The Benefits Management Framework and toolkit provided practical examples of how benefits can be established and measured in the Defence context.
325. Defence also advised that its Capability Acquisition and Sustainment Group has established the Program Management Centre of Expertise and Program Management Function that has produced new manuals, training materials and guidance for the functions of program management offices.³¹⁴
326. All of these efforts are promising and we welcome them. However, we caution that PMOs on their own will not improve project management capability within organisations. We are keen to ensure that the broader organisation supports the functions and accepts the advice of these PMOs.
327. According to the Axelos Portfolio, Programs and Project methodology, common problems that hinder the ability of PMOs to improve project management capability include:
- lack of senior executive buy-in and support for PMO functions and processes
 - the perception that it represents a challenge to the dominant culture or ‘way we do things around here’ resulting in a lack of commitment at best or sabotage at worst, with the potential for failure being higher if the embedded culture is at senior management level
 - the perceived (or actual) bureaucracy associated with compliance with repeatable processes and governance arrangements
 - inadequate use of the individual project or program management offices or lack of integration with other functions within the wider organisation
 - lack of clarity in the role(s), responsibilities and accountabilities of PMO staff
 - lack of clarity in the scope of individual project or program management offices.³¹⁵

328. We also note that Defence has not explained if or how these PMOs relate to each other.³¹⁶ This creates the risk of duplication or of them using conflicting methodologies, as all three PMOs are likely to be involved in the implementation of our recommendations.
329. Defence has advised that:
- each Project or Program Management Office (PMO) has a different role within Defence dependant on the project or program type they were set up for. There is no set PMO structure within Defence, and there are no PMOs that have the role of enterprise-wide management and/or coordination of all other PMOs.³¹⁷
330. Despite this, the Strategic Project Management Office, Joint Health Command PMO and Mental Health and Wellbeing PMO each identify their role in supporting implementation of our recommendations.³¹⁸ In none of its responses to this Royal Commission, including during procedural fairness processes, has Defence explained how the PMOs will work together towards the implementation of our recommendations. This may indicate that it has yet to be considered.
331. Defence advised as part of its response that the Royal Commission into Defence and Veteran Suicide Taskforce will pivot in mid-to-late 2024 to become the Royal Commission Reform Taskforce and will contain the existing taskforce's PMO. It advised that this PMO will be expanded and resourced to centrally manage the coordination and oversight across Defence of the implementation of government-endorsed recommendations of this final report. The level of governance will be elevated, with the Chief of the Defence Force becoming the senior responsible officer.³¹⁹
332. This is promising and may address our concerns about the management and coordination of the implementation of our recommendations. However, we do ask that this include consideration of the enterprise-wide management and coordination of project management practices to avoid inefficiencies and duplication of effort across PMOs.
333. We have previously highlighted the administrative burden on busy managers related to governance reporting and compliance. We encourage Defence to carefully consider the implementation of improved project management practices with busy middle managers in mind. We are keen to ensure that the full benefit of the PMOs is realised.
334. In the following sections, we discuss the recent establishment of the Chief of Personnel position, the establishment of the Mental Health and Wellbeing Branch and the implementation of Defence's response to the Afghanistan Inquiry Reform Program. These represent important efforts in overcoming some of the limitations we have highlighted in this chapter.

335. We have referred to the Afghanistan Inquiry Implementation Oversight Panel (the panel) throughout this report. The panel was established to assure the Minister for Defence of the thoroughness and effectiveness of Defence's response to the implementation of the Afghanistan Inquiry's recommendations, known as the Afghanistan Reform Program.³²⁰
336. This is of interest to us, as these efforts give an indication of Defence's possible approach to our own recommendations. Defence advised us that the approach taken to our interim report, including its focus on benefits realisation, was based on its response to the Afghanistan Inquiry Reform Program recommendations.³²¹

11.7.1 Establishing the Chief of Personnel position

337. In 2023 the Australian Government issued a directive that established the role of Chief of Personnel, a three-star role. Reporting directly to the Chief of the Defence Force, the new role was designed to be responsible for the new single, integrated system of ADF personnel management. At the same time, a range of complementary reforms were made across the Defence People System.³²²
338. Defence said it has improved accountability by establishing the role of Chief of Personnel and updating the governance framework of Defence People System, advising us:

The Defence People System Operating System (DPS OS) is a governance framework that maps and clarifies the accountable officers, responsible officers, outcomes, activities, performance and risk across the functions within the Defence People System. The initial artefacts associated with the DPS OS are the RASCI [Responsible, Accountable, Support Consulted and Informed matrix], Plan on a Page and the Planned Results Tables. These artefacts provide the measures to monitor progress and measure the end states.³²³

339. In relation to measuring the effectiveness of initiatives to improve the wellbeing of the whole Defence workforce, Defence told us it has delayed by another year because the metrics are still in development:

the Joint Directive clearly articulates the expectation to enhance the 'safety and mental health and wellbeing of the total workforce' (by 1 November 2024, as per the description of Phase 3). Relevantly, in a clear example of Defence's deliberate approach to monitoring progress, it has been necessary, in evolving the personnel system, to recognise the need to extend the timeframe for the realisation of that expectation, until the metrics to evaluate safety, mental health and wellbeing of the workforce are further developed. That measure is now extended to 1 November 2025.³²⁴

340. The inaugural Chief of Personnel, Lieutenant General Natasha Fox AO CSC, told us she was improving the system by which outcomes are measured and accounted for. Specifically, this meant by creating a table that mapped outcomes of the Portfolio Budget Statement Program, the corporate plan, corporate plan activities, enterprise priorities and accountability for the roles, as well as supporting outcomes.³²⁵
341. While we see these as positive statements of intent, we note – and not for the first time – that we cannot comment on the effectiveness of these efforts. We hope that the intent as outlined is realised with a sense of urgency.
342. The challenges facing the Chief of Personnel are complex, systemic and entrenched. The responsibilities of the role, as outlined in the joint directive, are significant and include:
- being the ADF policy lead for military personnel management
 - having authority over enlistment into the ADF, postings, advancement and promotions, transfers, voluntary and involuntary separations, transition, and military medical standards
 - being the ‘policy owner’ for the military justice system
 - having responsibility for ADF staffing across all groups and services.³²⁶
343. When asked about human and financial resourcing, the new Chief of Personnel, Lieutenant General Fox, said ‘I do need some additional people and so I have indicated I would like a deputy to assist me in my role’.³²⁷ She went on to explain that following discussions with the Chief Financial Officer, she has been allocated the funding she required.³²⁸
344. We note the significant scope and responsibilities of the Chief of Personnel’s role. Lieutenant General Fox must be adequately supported to achieve the complex reform required, noting that the bulk of our recommendations will require the Chief of Personnel to act as executive sponsor.

11.7.2 Establishing the Mental Health and Wellbeing Branch

345. The Chief of the Defence Force approved the creation of the one-star position of Director General of Mental Health and Wellbeing (the Director General) in 2022 (originally named the Director General of Mental Health Awareness, Resilience and Suicide Prevention).
346. This senior ADF position is the One Defence enterprise lead for mental health across all Defence personnel (including serving ADF members and Australian Public Service personnel), with responsibility for establishing the Mental Health and Wellbeing Branch (the MHW Branch), including establishing a charter, branch structure and supporting governance processes.³²⁹

347. Prior to the creation of the Director General role, there was no single officer in Defence with a primary enterprise-wide focus on the mental health and wellbeing of Defence personnel.³³⁰ The role was created in acknowledgement of the need to improve mental health and wellbeing responses as identified in a range of reviews, including the Productivity Commission's 2019 report *A Better Way to Support Veterans*.³³¹ This report stated that Defence should develop a proactive response to mental health and wellbeing, and focus on whole-of-life wellbeing.³³²
348. Brigadier Caitlin Langford was appointed as Director General of Mental Health and Wellbeing in November 2022.³³³ She gave evidence at our hearings in May 2023 and March 2024, informing us of progress made in establishing the MHW Branch.
349. We were told in May 2023 that the MHW Branch was expected to be in a 'mature delivery state' in January 2025;³³⁴ however, in March 2024, Brigadier Langford clarified that 'mature' meant that all positions would have been established and filled.³³⁵ She said that the branch would not, at that time, have 'functional development and output'.³³⁶ It appears that Defence increased its focus on establishing the MHW Branch following our public hearing in May 2023, particularly in resourcing it and transferring functions to it.³³⁷
350. The MHW Branch will be Defence's principal lead for workforce mental health and wellbeing.³³⁸ Defence describes suicide prevention as the branch's 'highest priority'.³³⁹ To fulfil this purpose, the MHW Branch will 'provide policy advice to improve Defence's mental health and suicide prevention system, and act as a catalyst for change to achieve improvements in workforce wellbeing'.³⁴⁰
351. While we commend this effort, we note that this is a full five years after the Productivity Commission's report and more than seven years after the National Mental Health Commission report into suicide and self-harm prevention services available to current and former serving ADF members and their families.³⁴¹
352. The MHW Branch will be responsible for conducting enterprise-wide monitoring and analysis of data on mental wellbeing, suicide and suicidality. It will achieve this by collecting and analysing data, and translating the insights into improvements to mental health and wellbeing management across the enterprise. As part of this, Defence will establish a strategic advisory group within the MHW Branch to share research findings. In her testimony, Brigadier Langford confirmed that a suicidologist and workforce psychologist will form part of the group's staffing arrangements.³⁴²
353. We recognise that the complexity of suicide prevention and the challenges in implementing this major reform mean it will take time to get right. Brigadier Langford emphasised that the branch was prioritising the improvement of suicide monitoring and data collection and analysis. She talked about the branch's significant efforts in ensuring it recruited people with the right skills to deliver these functions.³⁴³

354. That all being said, we consider progress in delivering a functional branch to be unacceptably slow. Given the seriousness of the harm it is intended to minimise and the urgency of the national tragedy of defence and veteran suicide, which is currently taking the lives of an average of three serving or ex-serving members every fortnight,³⁴⁴ we would have expected a greater sense of urgency. This protracted timeframe represents a lost opportunity to minimising service-related risk factors for suicide and suicidality.
355. We discuss the work of the Mental Health and Wellbeing branch in greater detail in Chapter 15 Promoting health and wellbeing among ADF members.

11.7.3 Defence's response to the Afghanistan Inquiry Reform Program recommendations

356. Following the Afghanistan Inquiry, the Afghanistan Inquiry Implementation Oversight Panel was established to provide external oversight and assurance of Defence's responses to the inquiry, as documented in the Afghanistan Inquiry Reform Plan.³⁴⁵ This plan sets out the Defence strategy for responding to the recommendations from the Afghanistan Inquiry and focuses particularly on benefits realisation.³⁴⁶
357. Defence told us it will look to the approach of the Afghanistan Inquiry Reform Program to implement our recommendations. Air Vice-Marshal Barbara Courtney AM, head of Defence's Royal Commission Taskforce, told us:

The reason that we spoke to the ... [Afghanistan] team was they were the most contemporary team that were implementing recommendations. And it occurred to us that they had reform that was required – very, very wide-ranging reform and they had been required to report very, very frequently and also for there to be an enduring measurement of the work that they had done. So, it seemed to us to be a model that fit what we thought needed to be done in order to make sure we not only delivered recommendations, but we tested them to see did they actually work.³⁴⁷

358. The Commonwealth has subsequently acknowledged through the procedural fairness process that there are opportunities for Defence to improve in its implementation of future recommendations, including in benefits realisation. The testimony from Air Vice-Marshal Courtney suggests an intention for a 'forward leaning approach to reform'.³⁴⁸

359. The final report of the Afghanistan Inquiry Implementation Oversight Panel stated:

The Panel considers Defence has delivered the wide-ranging and complex Reform Plan to a level or standard which meets the Minister for Defence's requirement for assurance.³⁴⁹

360. The report qualified this, saying that Defence was still preparing a report of work and outcomes that was expected to be finalised in 2024. The panel said the ultimate success of reforms will depend on ongoing commitment to their implementation. It also highlighted the importance of Defence reviewing all policy development and enhancement initiatives on a regular basis.³⁵⁰
361. There is no doubt that we are seeing from Defence a greater commitment to measure the benefits that result from an implementation activity. However, we are nevertheless concerned that some examples of its 'benefits realisation' still seem to be ticking off 'activities' rather than actually assessing outcomes to determine whether benefits have been generated.
362. For example, Defence closed the Defence Identity Workstream Initiative, which was an initiative relevant to the Afghanistan Inquiry Reform, before its object was met. In the request to close this initiative, it was noted that not all recommendations had been implemented.³⁵¹ However, in the request to close it, the report stated that the 'benefits and outcomes' had been achieved.³⁵²
363. The Associate Secretary of Defence told us that when programs are being considered for closure, 'we acknowledge the change that we've made but the need to continue at it and, indeed, in the check-in-three-years, there's an acknowledgement that there is a risk that it won't stay on the right trajectory'.³⁵³
364. To add weight to our concerns, there are no reported measures of benefits and outcomes in the Defence Identity Closure Report. The work program related to this initiative has been closed, despite there being no evidence that it was evaluated.
365. We discuss Defence's consideration of the recommendations related to the Defence Identity Workstream Initiative in Chapter 7, Culture and leadership. We found the 'next steps' for implementation to be vague. The language used was that the 'intent' of particular recommendations would be incorporated into the Culture Blueprint.
366. We found a similar example in the Organisational Learnings item of the Afghanistan Inquiry Reform Program. The then Chief of the Defence Force appointed Major General Andrew Hocking to lead a study of organisational learnings from the Afghanistan campaign between 2011 and 2021 as part of the 'Organisational Arrangements and Command Accountability Stream' of the Afghanistan Inquiry Reform Program.³⁵⁴ The study was known as the 'Hocking review'.
367. The Hocking review identified lessons to be learned in strategy-making, campaign design, command and control, culture, learning systems and risk management. It considered initiatives of the Afghanistan Inquiry Reform Program going forward.³⁵⁵
368. The final report of the Afghanistan Inquiry Implementation Oversight Panel highlighted the risk of Defence not listening to the Hocking review, saying it could result in 'important lessons from Afghanistan being overlooked'.³⁵⁶ This is ironic given that the focus of that review was to learn lessons from the Afghanistan campaign.

369. In his evidence, Associate Secretary of Defence Matthew Yannopoulos told us that:

- The Organisational Learnings workstream was closed by the Program Board on 12 April 2022 following publication of the Hocking review on the Defence website in March 2022.³⁵⁷
- At the time, the recommendations of the Hocking review were yet to be considered by the Chiefs of Services Committee and, in fact, no implementation plan for the recommendations existed.³⁵⁸

370. The Benefit Review of the Organisational Learnings initiative was prepared on 12 July 2022 and stated that the ‘benefits were validated’.³⁵⁹ However, none of the benefits listed are based on an assessment of effectiveness. Instead, the review listed the identified lessons and recommendations as benefits.³⁶⁰

371. The only assessment of a benefit was simply that the report had been published (an activity measure) and that briefings with Defence personnel had occurred.³⁶¹ While publishing the report is undoubtedly significant and sharing its findings with Defence personnel is necessary, these activities alone are not sufficient for benefits assessment.

372. To return to Defence’s Benefits Management Framework, it states that ‘benefits measures can also assist in providing assurance of program performance, monitor capability realisation and provide early warning of risks and issues’.³⁶²

373. Remembering also the report from the *First Principles Review: Creating One Defence*, cited earlier, which stated that Defence’s ‘change-averse’ culture had influenced its processes for implementing recommendations. It gave examples where Defence had ‘added veneers of process, papered over the concerns of reviewers and the findings of auditors, and avoided fixing the underlying problems’.³⁶³

374. We are concerned that ‘benefits’ is not always used to mean tangible measurable outcomes of a particular activity, but, as in the example quoted above, can be ascribed to activities that are simply ticked off and counted as ‘fulfilled’.

375. Returning to the example of the Benefit Review of the Organisational Learnings initiative, the Associate Secretary of Defence said there needs to be a way of:

enabl[ing] programs to close when their substantive work is done and ensuring there is a positive handover to the next accountable person or process to continue the monitoring and ... its effectiveness³⁶⁴

376. This approach sounds feasible; however, it relies on crystal clear accountability over a period longer than the project’s duration, if ongoing monitoring of benefits is to occur after project closure. Defence advised us that in January 2024, a Program Closure Directorate was established within the Afghanistan Inquiry Response Taskforce to monitor the completion of closed initiatives with residual work. This includes verifying completed work, comparing results with objectives, and re-evaluating previous benefit scores.³⁶⁵

377. Defence noted that benefits could be complex and recognised the need for interim measures to assess changes over the shorter term, while allowing the necessary time for the full change to take effect. Defence also reported that a whole-of-program post-implementation audit, directed by the Defence Committee in February 2024, was scheduled to occur three years after program closure. It said this would provide a better picture of the reform program's performance and impact.³⁶⁶
378. Defence has provided us with an overview of prospective work on benefits realisation that it intends to conduct.³⁶⁷ However, given this work is relatively recent, we cannot comment on how effectively it is being implemented to resolve the issues we have identified in this section.
379. During our final series of public hearings, Air Vice-Marshal Courtney told us that Defence is placing a stronger focus on measuring benefits. She said:
- the method, of course, is to make sure that delivering the recommendation or delivering the initiative that you believe meets the recommendation is one part of the process, but if you don't understand whether it worked then you won't know whether you've actually delivered it properly. Is there something else that, now that it's been fielded, ... would make it more effective? And going through that process of ... auditing and education and willingness to change and to adjust to make sure that the intent of the recommendation has been met [is important].³⁶⁸
380. Because these reforms to improve project governance are only in the early stages of development, there is no opportunity for the Royal Commission to comment on their effectiveness. However, given the history of Defence's 'set and forget' culture, there needs to be a continued and external spotlight on these efforts as we discuss in Chapter 30, Beyond the Royal Commission.
381. Defence must continue to improve project governance and management practices to ensure discipline and rigour are applied to reform efforts, and that members and veterans are delivered the change that they deserve.

11.7.4 Improving project management capability

382. Defence has established a Benefits Management Framework and project or program management offices (PMOs). These are good steps forward and provide Defence with good-practice concepts. We recommend that Defence engages independent expertise to undertake a project management maturity assessment. This will help Defence identify strengths and weaknesses in its project management capability in the areas of the enterprise responsible for implementing our recommendations.
383. Project management maturity assessments help organisations 'understand the underlying issues and to assess and document the current state ... in relation to portfolio, programme and project management'.³⁶⁹

384. Maturity assessments would consider many of the issues we have identified related to project management governance. These include benefits management, executive sponsorship and workforce skills and capabilities. Maturity assessments also consider the adequacy of existing templates, such as project plans and status reporting.
385. We also recommend that Defence develop a blueprint for improving its project management capability across the areas identified in the maturity assessment.
386. A blueprint or improvement plan is developed based on the needs and issues identified in the review. It allows PMOs to target their efforts and resources, and governance oversight to be directed to the areas of greatest need.³⁷⁰
387. We encourage the Department of Defence to consider establishing an Enterprise Portfolio Management Office (EPMO) to benefit the organisation more broadly in uplifting capability. An EPMO is the pinnacle of a 'P3O model' (portfolio, program and project) and if effectively implemented, could improve the delivery of business change (reform). It would do this by:
- operating and delivering services within the organization's matrix structure, ensuring that temporary structures such as programmes and projects can coexist with and enhance permanent functions and departments that support business as usual.³⁷¹
388. It is beyond the scope of our terms of reference to recommend establishing an EPMO, as it would sit at an enterprise level, whereas we are focused on project management capability in areas directly relevant to improving mental health and wellbeing and reducing suicide and suicidality among serving and ex-serving members.

Recommendation 41: Build project-management capability so that reform initiatives are successful

To build sustained capability to implement lasting policy changes, Defence should:

- (a) engage independent expertise to undertake a project management maturity assessment of the areas in Defence that will be responsible for implementing the recommendations of this Royal Commission
- (b) upon completion of the maturity assessment, develop a blueprint and implementation plan to deliver the improvements to those areas of project management capability that require an uplift
- (c) monitor the implementation of the capability uplift through to completion via a Tier 1 Committee.

11.8 The role of external oversight in supporting good governance and accountability

389. When Defence governance and accountability systems fail, external oversight bodies can step in and guide efforts for reform. Oversight functions can also support in the identification of system-wide factors or failings that contribute to defence and veteran suicide. They are also important in ensuring that Defence addresses these issues.
390. External oversight is a critical governance function that increases transparency, and improves accountability, integrity and compliance. In this section, we consider limitations of the ‘ecosystem’ of external oversight on Defence that have prevented oversight bodies from catalysing and supporting necessary change.
391. In the view of the Organisation for Economic Cooperation and Development, organisations that have external oversight functions should be empowered to investigate independently and hold institutions to account for problems affecting public integrity that internal mechanisms are failing to identify, remedy or deter.³⁷²

11.8.1 The external oversight ecosystem

392. There are several external bodies that oversee Defence processes and activities. They vary significantly in their functions and roles, as well as in the degree to which they oversee Defence’s conduct and decision-making under the law.
393. We consider the key external oversight bodies for Defence to be those that are permanent, have statutory independence, and have functions that influence the psychological health and wellbeing of Defence members.
394. We list some of these bodies, and we acknowledge that there are others that also provide relevant and important functions in holding Defence to account. The external oversight ecosystem of Defence comprises the following bodies:
- parliamentary committees, which investigate specific matters of governmental administration or performance, including Defence
 - the judicial system, which determines legal matters relating to Defence
 - Comcare, the regulatory agency that administers and enforces compliance with the *Work Health and Safety Act 2011* (Cth) and its regulations
 - the Commonwealth Ombudsman, who concurrently holds the office of the Defence Force Ombudsman. The Defence Force Ombudsman is an independent complaints and investigatory function for serving and former Defence members. It addresses administrative Defence matters and (since 2017), receives and investigates serious abuse within the ADF

- the Australian Human Rights Commission, which is an independent statutory body established under the *Australian Human Rights Commission Act 1986* (Cth) whose role it is to protect and promote human rights in Australia, by receiving and investigating complaints
- the Office of the Australian Information Commissioner, which is a regulatory agency that promotes and upholds individual rights of privacy and freedom of information, under the *Privacy Act 1988* (Cth) and the *Freedom of Information Act 1982* (Cth)
- the National Anti-Corruption Commission, which is an independent federal integrity agency established under the *National Anti-Corruption Commission Act 2022* (Cth) to prevent, detect, investigate and report on corruption in the Commonwealth public sector
- the Australian National Audit Office (ANAO), which provides audit and assurance services to the Parliament and Commonwealth public sector entities and statutory bodies, including reviews of public sector performance.³⁷³

395. We acknowledge that there have been important temporary external oversight bodies that have carried out important functions and that pre-date this Royal Commission. These include the interim National Commissioner for Defence and Veteran Suicide Prevention, and the Afghanistan Inquiry Implementation Oversight Panel.

396. As noted above, the Productivity Commission, which considers Defence outcomes from time to time, inquired into the system of compensation and rehabilitation for veterans.³⁷⁴ Its recommendations are important and we have referenced them throughout this report.

397. The Inspector-General of the ADF (the Inspector-General) is not considered an external oversight body. While the Inspector-General is appointed by the Minister for Defence, the role reports to the Chief of the Defence Force.³⁷⁵ This is the topic of Chapter 12, Role and functions of the Inspector-General of the ADF.

398. We have considered three external oversight bodies and made observations about their functions in overseeing Defence. These are Comcare, the Australian Human Rights Commission (AHRC) and the Defence Force Ombudsman. All three of these agencies have played a significant role in providing external oversight of Defence on matters of interest to our terms of reference.

- Comcare oversees Defence systems and processes related to workplace health and safety as the regulator and thus has an important role in ensuring Defence is adequately addressing psychosocial hazards to serving members. We discuss Comcare in detail in Chapter 13, Oversight of Defence workplace health and safety.
- AHRC has formed a ‘collaborative agreement’ with Defence, which is not strictly an external oversight mechanism, but is how AHRC evaluates cultural reform activities implemented under the collaboration.³⁷⁶

- The Defence Force Ombudsman receives complaints from ADF members about a range of matters, including military justice, and has also undertaken inquiries into Defence's policies and procedures related to complaints management. Those inquiries are referred to in Chapter 9, Unacceptable behaviour and complaints management.
399. The effectiveness of external oversight functions relies on Defence's cooperation and willingness to share information. We heard evidence that cooperation is not always forthcoming.
400. We received evidence from Comcare and AHRC as follows:
- The CEO of Comcare said that while there is a strong relationship with Defence's leadership, buy-in at lower levels of the organisation can be challenging and there needs to be a stronger commitment by Defence leaders to embed changes to mitigate psychosocial harm at all levels. Comcare acknowledged that 'better data would improve its ability to identify and respond to such risks.'³⁷⁷
 - AHRC referred to inconsistencies in Defence's approach to sharing data through the collaboration, which is an agreement between Defence and AHRC to support and improve Defence cultural reform priorities.³⁷⁸
401. When an oversight body makes recommendations to improve Defence's operations and systems, including to ensure they comply with the law, any follow-up by the oversight body should ideally consider not only whether the recommendation has been implemented, but also whether it has been effective in making practical and meaningful change.
402. In section 11.8.2 we consider how effectively Defence has implemented recommendations made by these bodies.

11.8.2 Determining whether actions have been effective

403. Some external oversight bodies are empowered to investigate Defence, examine the conduct and actions of Defence, and to recommend or compel change on matters that affect the mental health and wellbeing of Defence members. For example:
- By law, Comcare can advise Defence on work health and safety matters and issue improvement notices, as well as auditing Defence's response to these notices. However, as discussed in Chapter 13, Oversight of Defence workplace health and safety, these audits only assess if recommended actions were taken, not whether those actions were effective.³⁷⁹
 - The Defence Force Ombudsman told us it 'can and has reviewed the effectiveness of Defence's policies and procedures' but only 'where it has been identified as an appropriate focus for an own motion investigation conducted as part of the Ombudsman's usual functions'.³⁸⁰

404. External oversight bodies may check to see whether an organisation has implemented a recommendation; that is, whether the organisation has made the changes required by that recommendation. However, rarely do oversight bodies look into whether those actions or recommendations have actually been effective in making meaningful change.
- The Defence Force Ombudsman, for example, ‘does not, as a matter of course, review the effectiveness of implementation of its recommendations but may identify specific inquiries for which there is value in considering the effectiveness in practice on a case-by-case basis’ (as was the case in the 2023 Defending Fairness report).³⁸¹
 - Comcare can use its powers of inspection, investigation or inquiry to assess the effectiveness of Defence workplace health and safety policies, procedures or training.³⁸² However, as we noted in Chapter 13, Oversight of Defence workplace health and safety, Comcare inspector reports on incidents of suicide and self-harm (in 2020 and 2021, involving serving members) and on bullying and harassment (at Holsworthy Barracks) do not indicate that implementation effectiveness of Defence policies and procedures was evaluated as part of these inspections.
 - The Australian Human Rights Commission (AHRC) ‘collaborative agreement’ exists between Defence and AHRC and is not strictly speaking an external oversight mechanism. However, we have observed similar limitations in measuring implementation effectiveness. AHRC told us that the collaboration entails a ‘limited monitoring and evaluation capacity’³⁸³ and ‘does not always provide AHRC with information on if, when or how Defence responds to recommendations’.³⁸⁴ AHRC and Defence have only very recently begun to develop processes to evaluate cultural reform activities implemented under the collaboration. These include:
 - introducing a biannual reporting cycle to capture activity, outcomes, challenges and opportunities for improvement,³⁸⁵ with the first of these reports published already and the next one due in September 2024³⁸⁶
 - the development of a collaboration-level theory of change, which will provide a framework for future evaluation activities.³⁸⁷
405. Without measuring implementation effectiveness, it is difficult, if not impossible to assess whether real and meaningful change is occurring.
406. We acknowledge that each external oversight body is limited by the boundaries of the legislative powers conferred upon it. These influence the extent, form and subject matter of their oversight. Taken together, however, the bodies form an ‘ecosystem’ of external oversight.
407. While these entities are not responsible for the culture of Defence, they do play a key role in encouraging and pushing change. The external oversight ecosystem provides real opportunities for Defence to identify systemic issues that need to be addressed, and to do so before issues become significant.

11.9 Maintaining momentum

408. We acknowledge that safeguarding the health and wellbeing of employees is complex in any organisation where there are unavoidable risks associated with the workplace. We recognise that Defence has undertaken a range of activities to improve outcomes for its people.
409. The fact that suicide rates among serving and ex-serving members have remained stubbornly high for more than 20 years is, in part, symptomatic of Defence's failure to acknowledge and address service-related risk factors for suicide and suicidality. Critically, it is within Defence's control to improve its risk management and decision-making systems and by doing so, to do everything in its power to prevent further deaths by suicide in the Defence community.
410. In addition to enhancing internal mechanisms, we recommend the establishment of a dedicated independent entity to keep the pressure on Defence and continue to highlight the urgency of this issue. The combination of improved internal controls and greater external scrutiny will deliver the Australian Government the best opportunity to improve outcomes for ADF members and the ex-serving community.
411. Defence has acknowledged that being a serving member is not protective against suicide, as has historically been thought to be the case. Defence has outlined its intent to prioritise this issue. However, the history of inaction concerns us. Words matter, but effective delivery matters so much more and we are yet to see words translate into effective action.
412. The themes of this chapter are expanded on in Chapter 30, Beyond the Royal Commission. Currently, there is no independent scrutiny or oversight of the entire defence and veteran ecosystem and its performance in relation to suicide prevention. Improved oversight and strengthened accountability mechanisms are a crucial enabler for positive change.
413. The risk of Defence repeating the mistakes of the past is a matter of significant concern to us given the tragedy of each and every death by suicide.
414. Secretary of Defence Greg Moriarty indicated that Defence relies heavily on the enterprise governance structure to execute responsibilities relevant to health and wellbeing. He stated:

I view governance as the overarching mechanism which ensures Defence complies with applicable legislation and enables the Defence Diarchy to operate as intended and deliver the required outcomes for Defence's employees and the nation.³⁸⁸

415. Mr Moriarty also said:

As Secretary, the actions I take to monitor and understand suicidality, the risk factors in relation to suicide by ADF members, and the health, mental health and wellbeing of ADF members and the APS Defence workforce, occur through enterprise accountabilities, governance responsibilities and the Defence enterprise committee structures.³⁸⁹

416. This is concerning, given the issues highlighted throughout this chapter. Governance and accountability structures within Defence have failed to mitigate psychosocial harm and to eliminate or mitigate risk factors for suicide and suicidality that serving and ex-serving members are exposed to.

417. The final report of the Afghanistan Inquiry Implementation Oversight Panel draws attention to many important matters; of specific relevance to our inquiry is:

- the failure of senior leaders to acknowledge collective accountability and responsibility, which continues to generate resentment and anger among serving and ex-serving members and their families³⁹⁰
- the need to ensure that individual reforms were *collectively* addressing the root causes of the misconduct in Afghanistan and preparing the ADF and the special forces for the future³⁹¹
- the need for Defence leaders to consider how shortcomings in governance arrangements caused, allowed or contributed to the organisational failure.³⁹²

418. The Oversight Panel was established to provide assurance to the Minister for Defence regarding Defence's approach to implementing the Afghanistan Inquiry recommendations. Such an oversight function is an acknowledgment of the seriousness of the organisational failure, which led to deaths. We consider suicide and suicidality among serving and ex-serving members to warrant a similar external oversight body.

419. We welcome the acknowledgement by General Campbell that the findings of this Royal Commission represent a turning point, and who said:

this Royal Commission ... will be the first time that we have one of these forms of inquiry into Defence where you now have unitary values and behaviours, a unitary doctrinal foundation, a centralised holistic policy setting entity, a common foundation in whole-of-enterprise data and a single personnel system. I think those five profoundly different realities speak to the opportunities of this Royal Commission in allowing real, sustained difference to emerge because none of those factors that I described existed previously.³⁹³

420. We outline several recommendations in this report to tackle Defence's entrenched shortcomings in governance and accountability. We acknowledge the cultural challenges and complexities in implementing this task. We also highlight the glacial pace of change that preceded this Royal Commission.
421. In Chapter 30, Beyond the Royal Commission, we recommend establishing an independent and dedicated entity to keep the spotlight on Defence and drive momentum on this long-standing issue. This entity will be a partner in problem solving. It will ensure that change happens and the implementation of recommendations does not fall over in the face of inertia or complexity, as has been the case in the past.

Endnotes

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- 2 Commonwealth of Australia, Letters Patent, 8 July 2021, p 2.
- 3 Transcript, Peter Dunn, Hearing Block 10, 19 July 2023, p 70-6719 [33–35].
- 4 Transcript, Angus Campbell, Hearing Block 5, 23 June 2022, p 35-3375 [40].
- 5 Afghanistan Inquiry Implementation Oversight Panel, *Final Report to the Deputy Prime Minister and Minister for Defence*, November 2023 p ii, iv, v, 6, 21, 25, 32, 36, 41 (Exhibit BB-01.009, DVS.0000.0002.0668).
- 6 Exhibit 95-01.025, Hearing Block 12, Defence Enterprise Committee Framework – April 2023, DEF.1344.0002.0225 at 0226.
- 7 Australian National Audit Office, ‘Board Governance’, webpage, May 2019, p 4, www.anao.gov.au/work/insights/board-governance, viewed April 2024, (Exhibit WW-01.002, DVS.6666.0001.6990).
- 8 Australian National Audit Office, ‘Board Governance’, webpage, May 2019, p 4, www.anao.gov.au/work/insights/board-governance, viewed April 2024, (Exhibit WW-01.002, DVS.6666.0001.6990).
- 9 Australian National Audit Office, ‘Board Governance’, webpage, May 2019, p 5, www.anao.gov.au/work/insights/board-governance, viewed April 2024, (Exhibit WW-01.002, DVS.6666.0001.6990).
- 10 Macquarie Dictionary Online, ‘accountable’, webpage, last updated 2024, www.app.macquariedictionary.com.au/?search_word_type=dictionary&word=accountable, viewed 17 May 2024 (Exhibit ZZ-03.016, DVS.7777.0001.1075).
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- 12 Australian National Audit Office, ‘Corporate Planning and Performance Statements under the PGPA Act’, webpage, last updated August 2018, www.anao.gov.au/work/insights/corporate-planning-and-performance-statements-under-the-pgpa-act, viewed May 2024, p 6 (Exhibit WW-01.003, DVS.6666.0001.7010).
- 13 Transcript, Rufus Black, Hearing Block 12, 18 March 2024, p 94-9495 [15–20].
- 14 Transcript, Rufus Black, Hearing Block 12, 18 March 2024, p 94-9495 [25].
- 15 Australian National Audit Office, ‘Performance Measurement and Monitoring – Developing Performance Measures and Tracking Progress’, webpage, November 2020, p 2, www.anao.gov.au/work/insights/performance-measurement-and-monitoring-developing-performance-measures-and-tracking-progress, viewed April 2024 (Exhibit WW-01.006, DVS.6666.0001.7045).
- 16 Transcript, Rufus Black, Hearing Block 12, 18 March 2024, p 94-9501 [35–45].
- 17 Australian National Audit Office, ‘Performance Measurement and Monitoring – Developing Performance Measures and Tracking Progress’, webpage, November 2020, p 6, www.anao.gov.au/work/insights/performance-measurement-and-monitoring-developing-performance-measures-and-tracking-progress, viewed April 2024 (Exhibit WW-01.006, DVS.6666.0001.7045).
- 18 Australian National Audit Office, ‘Reporting Meaningful Performance Information’, webpage, June 2023, pp 6–7, www.anao.gov.au/work/insights/reporting-meaningful-performance-information, viewed April 2024 (Exhibit WW-01.008, DVS.6666.0001.7073).
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12 Role and functions of the Inspector-General of the ADF

Summary

The Inspector-General of the Australian Defence Force (the Inspector-General) plays a key role in relation to the Australian Defence Force (the ADF) military justice system.

Established to promote trust in the ADF and ensure all personnel have access to a fair and impartial military justice system, effective oversight of the military justice system and confidence in the discharge of the Inspector-General's functions is critical to ensuring the wellbeing of the system and of ADF members who engage with it.

The Inspector-General is supported by the Office of the Inspector-General of the Australian Defence Force (the Office of the IGADF), which consists of six directorates, four of which manage key functions of the Inspector-General:

- the *Directorate of Select Incident Review* (the DSIR), which undertakes inquiries into the deaths of ADF members, including deaths by suicide
- the *Directorate of Military Redress and Review* (the DMRR), which considers redress of grievance (ROG) complaints by serving members
- the *Directorate of Military Justice Performance Review* (the DMJPR), which conducts audits of ADF units regarding military justice matters
- the *Directorate of Inquiries and Investigations* (the DII), which conducts inquiries and investigations into alleged failures of the military justice system.

The work of the Inspector-General is relevant to our terms of reference for a number of reasons. For example:

- The military justice system overseen by the Inspector-General can impact the mental health and wellbeing of ADF members who engage with it, as can the Inspector-General's processes.
- The function of inquiring into the deaths of ADF members provides an opportunity to identify, investigate and analyse systemic issues, contributing factors and contributing risk factors to deaths by suicide.
- ROG complaints considered by the Inspector-General often concern involuntary termination of service, which is a risk factor in relation to suicide.
- Audits enable serious issues at unit level to be identified, including cultural issues and other conduct that are risk factors for suicide, such as unacceptable behaviour. They also record identified suicidal episodes.
- Inquiries into alleged failures of military justice often involve complaints concerning matters that can be suicide risk factors, such as unacceptable behaviour, abuse of authority and abuse of process.

We found that that there are several issues with the discharge of the Inspector-General's functions.

A principal concern relates to perceptions that the Inspector-General is not sufficiently independent of Defence. Whether or not such perceptions are well founded, they can undermine confidence in the Inspector-General's vital work in overseeing the military justice system, considering and inquiring into complaints, and inquiring into deaths of ADF members.

We propose reforms aimed at addressing such perceptions.

Other issues relate to matters such as:

- staffing challenges
- particular processes of the Office of the IGADF
- relevant skillsets and expertise
- timeliness
- engagement with members and families
- non-disclosure directions
- guidance and quality assurance
- further work, including trend analyses, that should be done
- the audit cycle
- own-initiative inquiries by the Inspector-General.

We also propose reforms to deal with these issues.

12.1 Introduction

1. The Inspector-General plays a key role in relation to the military justice system in the Australian Defence Force (ADF). Established to promote trust and justice in the ADF and to ensure that all personnel have access to a fair and impartial military justice system, the Inspector-General is intended to be an independent umpire to help support ADF members and their families when they have a complaint or concern, and ensure the health and effectiveness of the military justice system in the ADF.¹
2. Effective oversight of military justice and confidence in the discharge of the Inspector-General's functions is critical to the proper functioning of the military justice system. It is also critical to ensuring the wellbeing of ADF members and others who engage with it.
3. We have examined the Inspector-General's operations and identified where opportunities for improvement exist.
4. A principal issue is a perception that the Inspector-General is not sufficiently independent of Defence in the discharge of the role's functions. If the Inspector-General is not perceived as being sufficiently independent, there is a risk that ADF members may be deterred or discouraged from relying on the Inspector-General as a recourse when they experience unfairness in the military justice system. Confidence in the outcomes of military justice processes may also be eroded.
5. There are also shortcomings in particular processes of the Office of the IGADF, which supports the discharge of the Inspector-General's functions. This chapter discusses issues in relation to four key directorates of the Office of the IGADF. Section 12.3 refers to the Directorate of Select Incident Review (DSIR), section 12.4 refers to the Directorate on Military Redress and Review (DMRR), section 12.5 refers to the Directorate of Military Justice Performance Review (DMJPR) and section 12.6 refers to the Directorate of Inquiries and Investigations (DII).
6. There have been developments with respect to the Inspector-General and the Office of the IGADF since the Royal Commission's Hearing Block 11 in August and September 2023. A focus of Hearing Block 11 was the work and functions of the Inspector-General and the Office of the IGADF.
7. We have been advised that various changes have been made in relation to how several of the Inspector-General's functions are discharged. While we have not received evidence of these changes, we refer to them in our discussion of issues throughout this chapter.
8. Further, in September 2023 the Inspector-General, together with the Secretary of the Department of Defence and the Chief of the Defence Force (CDF), commissioned the *Twenty-Year Review of the Office of the Inspector-General of the Australian Defence Force* (the Twenty-Year Review). The review was conducted by the Hon Duncan Kerr, Chev LH SC, a former Judge of the Federal Court and President of the Administrative Appeals Tribunal.

9. According to its terms of reference, the Twenty-Year Review was to investigate and report on the basis by which the statutory office is established, and to consider the functions, operation and composition of the Office of the IGADF.²
10. A copy of Mr Kerr's report dated 21 March 2024 (the Twenty-Year Review Report) has been provided to us.³ Where relevant, we refer to the Twenty-Year Review in this chapter.
11. The material presented in this chapter relates closely to other chapters in this report, including Chapter 9, Unacceptable behaviour and complaints management, and Chapter 10, The ADF military justice system.

12.1.1 Connection to our terms of reference

12. The role of the Inspector-General and the discharge of the role's functions are relevant to our terms of reference, including part A, part B and part J.
13. For example:
 - The military justice system overseen by the Inspector-General can impact the mental health and wellbeing of ADF members who engage with it, as can the Inspector-General's processes.
 - The function of inquiring into the deaths of ADF members provides an opportunity to identify, investigate and analyse contributing risk factors to deaths by suicide, and identify systemic issues and common themes.
 - Redress of grievance (ROG) complaints considered by the Inspector-General often concern involuntary termination of service decisions, which are a risk factor in relation to suicide.
 - Audits enable serious issues at unit level to be identified, including cultural issues and other conduct that are risk factors for suicide, such as unacceptable behaviour. They also record identified suicidal episodes.
 - Inquiries into alleged failures of military justice may involve complaints concerning matters that can be contributing factors to suicide and negative mental health and wellbeing outcomes for ADF members, such as unacceptable behaviour, sexual misconduct, and abuse of authority.
14. We also consider that pursuant to part J of our terms of reference, all matters considered in this chapter are reasonably relevant to our inquiry.

12.1.2 Overview of the Inspector-General and the Office of the IGADF

15. The position of the Inspector-General was created in 2003 following the *Report of an Inquiry into Military Justice in the Australian Defence Force* by the Hon James Burchett QC (the Burchett Report). The report envisaged that the Inspector-General would:

[r]epresent the CDF in providing a constant scrutiny, independent of the ordinary chain of command, over the military justice system in the Australian Defence Force in order to ensure its health and effectiveness; and to provide an avenue by which any failure of military justice might be examined and exposed, not to supplant the existing processes of review by the provision of individual remedies, but in order to make sure that review and remedy are available, and that systematic causes of injustice (if they arise) are eliminated.⁴
16. Initially, the Inspector-General was established by and reported to the CDF.⁵
17. In 2005, amendments were made to the *Defence Act 1903* (Cth) (the Defence Act) which introduced Part VIIIB into the Act.⁶
18. Under Part VIIIB, the Inspector-General became a statutory position, to be appointed by the Minister for Defence. When making an appointment, the Minister is obliged to have regard to any recommendations by the CDF.⁷
19. The Inspector-General's initial functions were to:
 - inquire into or investigate matters concerning the military justice system
 - conduct performance reviews of the military justice system, including internal audits, at the times and in the manner the Inspector-General considers appropriate
 - advise on matters concerning the military justice system, including making recommendations for improvements
 - promote military justice values across the Defence Force
 - do anything incidental or conducive to the performance of these functions.⁸
20. Part VIIIB also provided that the Inspector-General could conduct inquiries and investigations on their own initiative, and if directed by the CDF or requested by a service chief or other individual to do so.⁹

21. Over time, the Inspector-General has been given additional functions, including to:
- inquire into or investigate complaints concerning service police officers (and advise on service police officer complaints-handling)
 - inquire into deaths of ADF members
 - oversee the statutory ROG system and consider complaints lodged under that system.¹⁰
22. The Minister may also now direct the Inspector-General to inquire into or investigate a matter concerning the Defence Force.¹¹
23. The functions of the Inspector-General are contained in section 110C of the Defence Act, section 5 of the *Inspector-General of the Australian Defence Force Regulation 2016* (Cth) (the IGADF Regulation) and sections 43–47 of the *Defence Regulation 2016* (Cth) (the Defence Regulation).¹²
24. Appointments as Inspector-General are for a term not exceeding five years, with eligibility for re-appointment.¹³
25. To date, only two people have held the position of Inspector-General. The first was Mr Geoff Earley AM, a former Commodore in the Navy, who was the Inspector-General from 2003 until 2015. At this time, Brigadier James Gaynor CSC, the then Deputy Inspector-General, was appointed as acting Inspector-General, and in December 2016, the Inspector-General.¹⁴ Mr Gaynor was re-appointed for a further five-year term with effect from 1 December 2021.
26. Both Mr Earley and Mr Gaynor had lengthy careers in the ADF prior to their appointments. According to Mr Gaynor, he resigned all forms of ADF service prior to assuming the role as Inspector-General, as did Mr Earley.¹⁵
27. The Inspector-General has a Deputy Inspector-General, who is an 07 level ADF Legal Officer.
28. The Office of the IGADF, which supports the Inspector-General, consists of six directorates, four of which manage the discharge of the Inspector-General's functions. These four directorates are:
- the DSIR, which undertakes inquiries into deaths of Defence Force members, including deaths by suicide
 - the DMRR, which considers ROG complaints by members
 - the DMJPR, which conducts military justice audits of ADF units
 - the DII, which conducts inquiries and investigations into alleged failures of the military justice system.¹⁶

29. The Office of the IGADF is staffed by permanent members of the ADF and ADF reservists made available by the CDF, and Australian Public Service (APS) personnel made available by the Secretary of the Department of Defence.¹⁷
30. ADF permanent members are seconded to the Office of the IGADF for a posting cycle, which is typically two or three years.¹⁸
31. Each of the directorates in the Office of the IGADF has a director. At the time of Hearing Block 11, the directors of the DSIR and DMJPR were 06 level ADF legal officers, the director of the DII was an ADF officer who was a lawyer by training, and the Director of the DMRR was an EL2 level public servant.¹⁹ In the DSIR, the Deputy Director, who was a 05 level ADF legal officer, was acting Director.²⁰
32. As at July 2023, there were 170 staff of the Office of the IGADF. Of these, 48 were permanent or full time, with 24 of these being seconded ADF permanent members and 24 being APS personnel made available by the Secretary of Defence. The 122 non-permanent staff were essentially ADF reservists drawn from the Navy (34), the Army (41) and the Air Force (46).²¹ ADF reservists who work for the Office of the IGADF are part time and render services on a days-per-task or days-per-year basis.²²
33. The current Inspector-General, Mr Gaynor, told us that the ADF permanent members in the full-time staff of the Office of the IGADF include some members for whom the office is their final posting within the ADF before they retire or transfer to the reserves. Otherwise, ADF permanent members seconded to the Office of the IGADF are posted back into roles in the ADF at the conclusion of their secondment.²³
34. The Inspector-General has the power to engage (on behalf of the Commonwealth) consultants with suitable qualifications and experience to perform services,²⁴ which the Inspector-General has done on occasions for specific pieces of work.²⁵ Consultants have been engaged to assist with caseloads, including of the DSIR²⁶ and the DMRR,²⁷ and to handle specific inquiries being conducted by the DII. Of the 115 matters that were open in the DII when the Director of the DII gave evidence to the Royal Commission, four were being handled by consultants.²⁸
35. The Inspector-General has a broad power to appoint people, including consultants, as 'inquiry officers', 'inquiry assistants' and 'Assistant IGADFs'.²⁹
36. The Inspector-General is given numerous powers in order to discharge the role's various functions. These are mostly contained in the IGADF Regulation.
37. Significantly, the Inspector-General does not have the power to overrule or alter command decisions. The Inspector-General can only make findings and recommendations that relate to actions taken by the ADF. Mr Gaynor put it this way: 'I do not have any executive authority to remedy those flaws. I make recommendations to officials who can.'³⁰

12.2 Independence

38. Independence is a key feature of the Inspector-General role. It is critical to the proper functioning of the position, and to the confidence of members and others in the oversight of the ADF military justice system. Perceptions about independence are also critical. This section focuses on perceptions that the Inspector-General is not sufficiently independent of Defence in the discharge of the role's functions.

12.2.1 Overview

39. A perception that the Inspector-General is not sufficiently independent of Defence has been expressed in evidence we have heard and asserted in submissions we have received.

40. Captain Mona Shindy CSC RAN, who had made complaints about alleged discrimination and poor treatment in her unit, gave evidence about her experience of two Inspector-General inquiries:

It is my opinion that the post of IGADF being held by a retired one-star military officer means that there is insufficient independence from the ADF organisation. Invisible power structures, allegiances, relationships and networks of influence are still too pervasive in relation to final decision making for inquiry findings.³¹

41. Another witness, Reverend Dr Nikki Coleman, said that she did not engage with the Inspector-General over her complaints of unacceptable behaviour because she was not confident that the Inspector-General was adequately independent. She said there is a perception that the Office of the IGADF is not an external body because it is staffed by uniformed members, and that her understanding from being a chaplain and supporting other people is that the Inspector-General is not seen as external to Defence.³² In testimony she put it bluntly: 'I don't believe that the IGADF is sufficiently independent.'³³

42. Another witness, MB1, said:

The Assistant Inspector-Generals who conduct inquiries are uniformed members of the Defence Force who are on a short-term posting of two to three years generally within the IGADF and after their time at the IGADF, they return back to their service, where they'll be posted or ... possibly subsequently promoted after that. I believe it's difficult for them to make adverse findings particularly against senior commanders, which may then adversely affect their own career prospects and development after they leave [the] Inspector-General's office. I also believed that the Inspector-General, himself, is a former Defence member and, therefore, will have relationships still within Defence, [which will] also compromise the integrity.³⁴

43. Witness MB1 said they believed the Office of the IGADF would be better off if it were:
- more independent from Defence by possible legislative amendments to both the Defence Act and the IGADF regulations in regards to the appointments of Assistant Inspector-Generals. I believe that a more civilian-run agency ... would be beneficial for Defence in removing any actual or perceived conflicts of interest by individuals charged to undertake inquiries and ... their connection to their relevant service.³⁵
44. Similar concerns have been asserted in submissions. It has been said, for example, that ‘the IGADF is simply a mechanism by which the ADF can mark its own homework’, and that there is ‘an umbilical attachment of the IGADF within the ADF chain of command’.³⁶
45. When giving evidence, Mr Gaynor acknowledged that he is aware of a perception that the Inspector-General is not independent of the chain of command and is too embedded in Defence.³⁷
46. The Director of the DII told us that she has had feedback from members that the Inspector-General is too inculcated with Defence, noting that this was a view of members whose matters had not been substantiated in their favour.³⁸
47. In a Complainant Feedback Survey conducted for the Inspector-General in 2021 in relation to complaints handled by the DII, only 35% of the 32 respondents agreed or strongly agreed that they felt the ‘person who handled the inquiry was impartial and non-judgemental’, with 21% neither agreeing nor disagreeing and 36% of respondents strongly disagreeing.³⁹ These results are notable, even given the total number of respondents was relatively small.
48. The Twenty-Year Review Report also highlighted issues about perceptions of independence, noting:
- The Review met with [redacted] and a number of other of the IGADF’s most stringent critics. It is grateful for the insights they offered. That the Review differs from their assessments is ultimately inconsequential. The views they expressed as to the IGADF’s perceived want of credible independence have become and are too widely shared and ingrained in public discussion to permit their concerns and perceptions to be ignored as unfounded or dismissed by bland reassurances to the contrary.⁴⁰
49. Perceptions that the Inspector-General is not sufficiently independent of Defence have the potential to be corrosive to the proper functioning of the role. Even if such perceptions are not well founded or are based on premises that may not be correct, they have the capacity to undermine or diminish confidence in the Inspector-General’s vital work in overseeing the military justice system, investigating and considering complaints, and inquiring into deaths of ADF members.

12.2.2 Perceptions about independence – relevant matters

The Inspector-General role is only designed to be independent of the ordinary chain of command

50. Independence has always been a key element of the legislative provisions concerning the Inspector-General. However, a particular form of independence is involved, namely that the Inspector-General is independent of the ordinary chain of command, rather than being independent of Defence.⁴¹ This understanding of ‘independence’ was a feature of the Burchett Report, which recommended that the position of Inspector-General be created. It is also incorporated in the provisions of Part VIIIB of the Defence Act concerning the statutory office of the Inspector-General.
51. Section 110A of the Defence Act, for example, makes this conception of independence clear in setting out the main object of the Inspector-General:

Provide the Chief of the Defence Force with:

- (a) a mechanism for internal audit and review of the military justice system independent of the ordinary chain of command; and
 - (b) an avenue, independent of the ordinary chain of command, by which failures and flaws in the military justice system can be exposed and examined so that the cause of any injustice (whether systemic or otherwise) may be remedied.⁴²
52. While there are reasons for independence being expressed in this way, a consequence is that it encourages, or at least permits, a view that the Inspector-General is part of Defence, particularly given the Inspector-General's main object is stated as being to provide services to the CDF. A structure of this kind is capable of furthering perceptions that the Inspector-General is not sufficiently independent of Defence.

Actions taken to enhance independence

53. Since the position of Inspector-General was created, legislative amendments have been made to strengthen the actual independence of the Inspector-General. Actions have also been taken by the Inspector-General to enhance the perceptions of independence of the position and of the Office of the IGADF.
54. For example, when the role was first created, the Inspector-General reported to the CDF. That was changed when the statutory office of the Inspector-General was legislated in 2005 so that the Inspector-General as appointed by the Minister, and other administrative provisions were enacted that were intended to strengthen the Inspector-General's autonomy. These provisions relate to matters such as tenure, remuneration –which, as with other statutory office holders, is to be determined by the Remuneration Tribunal – and termination, which only the Minister can do.⁴³

55. According to the Inspector-General, having the CDF and Secretary of the Department of Defence make personnel available to the Inspector-General to staff the Office of the IGADF, as specified in section 1100 of the Defence Act, is recognition of Parliament's commitment to the independence of the office.⁴⁴ It is said that this means Office of the IGADF staff are subject to the Inspector-General's direction and do not serve at the direction of any military command, and nor are they subject to the Department of Defence's hierarchy in performing the Inspector-General's functions. Reporting lines are through to the Inspector-General and not to ADF commanders or managers.⁴⁵
56. Subsequent amendments to the Act have:
- introduced a requirement that the Inspector-General report annually on the Office of the IGADF's operations to the Minister⁴⁶
 - conferred on the Inspector-General the power to cease an inquiry that the CDF has directed the Inspector-General to undertake⁴⁷
 - incorporated Division 4A in the IGADF Regulation providing for inquiries to be conducted by Assistant Inspectors-General who are judicial officers, where the Inspector-General is not to take part personally or give directions about an inquiry.⁴⁸
57. According to Mr Gaynor, inquiries undertaken within the Office of the IGADF often involve an ADF Assistant Inspector-General working with a civilian Assistant Inspector-General, and in some matters the ADF Assistant Inspector-General will be the strategic manager 'for civilians who are undertaking inquiries'.⁴⁹
58. Actions to enhance perceptions of independence have also been taken in the DII, with the Director of the DII telling us that staff in the directorate do not wear uniforms and that the Department of Defence and the ADF are considered 'completely external' to the Office of the IGADF. This means that if documents are needed from the Department of Defence or the ADF for an assessment or inquiry, they are sought formally, and if Office of the IGADF staff want to speak about a complaint with the ADF or the department, they usually seek consent from the member first.⁵⁰

Factors contributing to perceptions of insufficient independence

59. Despite the legislative and other actions referred to earlier in this section, in our view, there are several factors that may contribute to perceptions that the Inspector-General is not sufficiently independent of Defence.
60. We emphasise that we are concerned here with perceptions. We are not suggesting that the previous or present Inspector-General or the Office of the IGADF or its staff have, as a matter of fact, acted without the required independence.

61. The factors we believe may contribute to these perceptions include:

- the nature of the Inspector-General's independence, as discussed earlier in the section
- the Inspector-General being a statutory office holder under the Defence Act, and being in the Defence portfolio
- the Inspector-General's offices being located in Defence premises
- the Inspector-General's communications sometimes carrying branding of 'Australian Government – Defence' as well as that of the Inspector-General
- the only two people who have held the position of Inspector-General having had long careers in the ADF before being appointed to the role
- the Inspector-General largely relying on personnel made available by the CDF and the Secretary of the Department of Defence to staff the Office of the IGADF
- most of the Office of the IGADF staff being ADF permanent members or reservists
- directors of the directorates that assist with the discharge of the Inspector-General's functions being primarily drawn from the ADF
- in many cases, Assistant Inspectors-General of the ADF who conduct inquiries or consider matters being ADF permanent members or reservists
- ADF permanent members returning to postings in the ADF after completing secondments to the Office of the IGADF
- the composition of the staffing of the Office of the IGADF having been largely controlled by the CDF and the services
- the risk of unconscious bias on the part of ADF members who work in the Office of the IGADF.⁵¹

62. In regard to staffing, we have already referred to the fact that the staff of the Office of the IGADF largely comprises ADF permanent members and reservists. We have been further told that:

- (a) the Office of the IGADF has established positions to which each of the services post ADF members⁵²
- (b) the Inspector-General has had the right to choose their deputy, but otherwise they have only had a right to refuse ADF members nominated by the services to fill staff positions in the Office of the IGADF, including senior leadership positions such as directors of directorates⁵³
- (c) apart from selection of the Deputy Inspector-General, there has been no selection process by the Inspector-General for ADF permanent members and reservists posted to the Office of the IGADF, and the services or the Director of Military Legal Capability have chosen or been involved in choosing who is posted to the office⁵⁴

- (d) recently, the Inspector-General has sought to have a greater say in which ADF members are to fill senior positions in the Office of the IGADF, and has written to the CDF saying that in future he will be asking the services to nominate candidates so that he can run a selection process⁵⁵
 - (e) rather than having a senior legal officer nominated by the services as the Director of the DSIR, the Inspector-General has determined that he will instead 'civilianise' the position by having the role filled with an EL2 director from the APS.⁵⁶
63. Notwithstanding the changes referred to in (d) and (e), it is apparent that the composition of the staffing of the Office of the IGADF has been largely controlled by the ADF.
64. This is not to suggest that seconded ADF staff are directed or influenced by command when discharging duties for the Inspector-General. However, as Mr Gaynor acknowledged, the fact that it is Defence rather than the Inspector-General who chooses who will serve in the Office of the IGADF is something that may, at least, affect perceptions of whether the office's staff are independent.⁵⁷

There is a risk of unconscious bias

65. Mr Gaynor acknowledged the risk of unconscious bias in relation to ADF members in the permanent staff of the Office of the IGADF and in the office's reservist workforce.⁵⁸
66. Unconscious bias in favour of Defence can manifest in different ways, which may be difficult to discern and protect against. For example, it could involve:
- giving greater credit to the recollection of those higher in the command structure
 - prioritising the interests of the ADF as a whole over an individual complainant
 - adhering to known customs and habitual processes rather than identifying system-wide flaws
 - acting in ways that preserve one's career prospects and relationships with ADF colleagues.
67. In identifying the ways in which unconscious bias may manifest, we are by no means suggesting that in any particular instance an outcome has been influenced by such biases. Nor are we seeking to impugn or undermine the service that individual ADF members posted to the Office of the IGADF render to the office. Rather, we are identifying potential risks to the Inspector-General's and the Office of IGADF's perceived independence.

68. With respect to the staffing of the Office of the IGADF, Mr Gaynor said he believed the benefits of having cultural knowledge outweighed the risks of unconscious bias:

I don't deny that there is a risk of unconscious bias in connection with any person, but the ... Defence Force is not the size of a football team. The people in my office who work on inquiries tend to be members of the permanent force who have retired from the permanent force, they have transitioned to the Reserve and they ... have knowledge of the Defence Force and how it operates so that they know where to ask, where to go, they know what questions to ask. It is difficult to pull the wool over their eyes ... and I think that the benefits of using people with that knowledge and experience outweigh the risks of unconscious bias, which can be addressed in other ways.⁵⁹

69. Mr Gaynor considered that unconscious bias was mitigated by training on the Advanced Inquiry Officer course. This course is not mandatory but is 'usually' a precondition for working as an Assistant Inspector-General on an inquiry.⁶⁰ Mr Gaynor also said the DII and DSIR run annual in-service training with Assistant Inspectors-General who conduct inquiry work that discusses unconscious bias.⁶¹ We have also been told that the Inspector-General continually emphasises the message of functional independence through staff training such as annual workshops and in-service training.⁶²
70. The Director of the DII said that she is very aware of the potential for unconscious biases in her staff. She conducts training for new Assistant Inspectors-General that prompts participants to actively think about their biases – in terms of making assumptions that Defence is always right or that complainants are always badly treated – and explicitly says that they need to come from a position where they are neutral, noting that this is difficult to achieve fully.⁶³
71. The Director also said the risk of unconscious bias is reduced in the case of reservists for whom working for the Office of the IGADF is their last role before retirement.⁶⁴
72. The extent to which this training not only raises awareness of the risks of unconscious bias but also successfully addresses those risks is unknown to the Royal Commission. However, the fact that training of this kind is provided is itself recognition that unconscious bias is a risk with Office of the IGADF staff who are drawn from the ADF. That risk contributes to perceptions about the Inspector-General's lack of independence.
73. There are also other matters that we believe are capable of encouraging a view that the Inspector-General is overly intertwined with Defence, which in turn can lead to or strengthen perceptions that the Inspector-General is not sufficiently independent.

The Inspector-General's reports to the CDF

74. The first of these matters is the way in which the Inspector-General reports to the CDF. Under the Defence Act, the Inspector-General is not appointed by the CDF and does not report to the CDF.⁶⁵ In practice, however, Mr Gaynor regularly engages with and provides reports to the CDF. This includes monthly updating reports – described as ‘Noting Briefs for CDF: IGADF Monthly Update Brief’. Copies of the monthly reports from February 2020 to May 2023 have been provided to us.
75. One view is that this form of reporting is consistent with Mr Gaynor’s characterisation of the CDF as his ‘principal customer by virtue of section 110A of the [Defence] Act’.⁶⁶
76. It is appropriate, and most likely necessary, that Mr Gaynor provide a level of reporting to the CDF. However, from our observation, updates provided in the monthly Noting Briefs stray on occasion into reporting on how the IGADF is able to perform its functions, rather than only communicating specific outcomes, substantive recommendations or systemic improvements to the military justice system.
77. For example, in the April 2023 update, Mr Gaynor reported on how the Twenty-Year Review was proceeding, and expressed concern that delay in producing documents to this Royal Commission may cause the Commission to ‘draw negative inferences about [the Office of the] IGADF’.⁶⁷
78. In another example, from May 2022, Mr Gaynor noted to the CDF matters relating to training, staffing challenges and requests made to the Office of the IGADF by the Office of the Special Investigator.⁶⁸
79. In some other reports, there are updates on the progress of significant cases under review by the Inspector-General, and advance notice of the likely outcomes of an inquiry or investigation is sometimes given.
80. The content of some of the monthly Noting Briefs might be likened to updates provided to a supervisor.
81. Mr Gaynor said the updates were a method he used to raise issues of concern and draw other matters to the attention of the CDF.⁶⁹
82. In our view, the nature and frequency of reporting by Mr Gaynor to the CDF does not help counter a perception that the Inspector-General is not sufficiently independent of Defence.

Participation in the Military Justice Steering Group

83. The second matter is the Inspector-General’s participation in the Defence Force’s Military Justice Steering Group (the MJSG), a senior committee in Defence comprising senior officials from Defence Legal and the Service Headquarters.⁷⁰

84. The role of the MJSG is to 'provide assurance to the [Vice Chief of the Defence Force] that the military justice system is operating effectively and efficiently'.⁷¹ Mr Gaynor described the role of the MJSG as advising the CDF on military justice policy and changes to military justice law.⁷²
85. The Inspector-General is an 'active contributor' to the MJSG, as well as to the Military Justice Legal Forum, which makes recommendations to the MJSG to resolve specialist military justice and discipline law issues.⁷³
86. Having the Inspector-General as an active contributor to the MJSG has benefits – for example, the Inspector-General can share their insights about trends and potential flaws in the military justice system. There would also be efficiencies for both Defence leadership and the Inspector-General because they receive regular updates about each other's activities in these cooperative sessions.
87. On the other hand, the Inspector-General's participation in the MJSG may encourage a perception that the Inspector-General is participating in and advising upon the MJSG's decisions and activities, rather than keeping to the Inspector-General's separate oversight role.
88. Mr Gaynor appears to have recognised the possibility of perception issues arising out of his involvement in the MJSG. According to the minutes of the June 2022 MJSG meeting, he moved to have the status of the Inspector-General changed from 'member of the MJSG' to 'permanently invited guest', with a stated reason for this change being that it would enhance the perception of independence.⁷⁴
89. The regular contact between the Inspector-General and the MJSG also risks intertwining their functions. There is an indication in the minutes that the Inspector-General may be viewed as a resource that the MJSG can use to assist its work.
90. On one occasion, the MJSG sought an update from the Inspector-General on the progress of an Inspector-General own-initiative inquiry, which it anticipated might result in recommendations for reform, while the inquiry was still in train.⁷⁵ On another occasion, Mr Gaynor noted to the MJSG that it would be possible for the Inspector-General to conduct an own-initiative inquiry into a matter that had been raised for discussion by the group and that the services indicated they may lack the resources to address.⁷⁶
91. While it is certainly true that the Inspector-General's performance of their functions can assist the MJSG, we consider it important that structural distinctions are rigorously enforced to prevent the Inspector-General from being perceived as a resource of the ADF.
92. In making these observations, we do not suggest that the Inspector-General has breached any legislative restrictions or acted beyond the scope of his role.
93. What we are concerned with, however, is the perception that the Inspector-General is not sufficiently independent of Defence. The nature of the Inspector-General's involvement with the MJSG does not help to lessen any such perception.

12.2.3 Reforms to improve confidence in the independence of the Inspector-General

94. In our view, reforms are required to address perceptions of insufficient independence of the Inspector-General and the Office of the IGADF from Defence. Such reforms will enhance members' confidence that failures and flaws in the military justice system will be exposed and injustices may be remedied.

Independent entity status

95. An issue raised during Hearing Block 11 was whether the Inspector-General should be given independent entity status under the *Public Governance, Performance and Accountability Act 2013* (Cth) and become a Commonwealth agency responsible for its own administration.
96. Mr Gaynor told us that if this were to occur, it could enhance perceptions of the Inspector-General's independence, and also address some of the commentary he said he was aware of concerning perceptions of the Office of the IGADF.⁷⁷ Mr Gaynor said:

Mr Gaynor: Once again, counsel, because I am keen to continue the evolution of IGADF as an independent office and I see entity status as the next step in IGADF's evolution.

Erin Longbottom: Am I right to understand from that answer, you see it as being a step that might enhance the independence of your office?

Mr Gaynor: Yes, counsel ...

Mr Gaynor: ... But in terms of perceptions, I see IGADF as an independent separate entity with its own separate legislation as delivering advantages in terms of perceptions of IGADF's independence ...⁷⁸

97. The issue of whether the Inspector-General should have status as an independent entity is a matter that Mr Gaynor said he wanted the Twenty-Year Review to consider.⁷⁹
98. The possible advantages in relation to perceptions about the Inspector-General's independence are not the only consideration when deciding whether the Inspector-General should have status as an independent entity. The decision involves a range of other issues and considerations.

99. Because of this, we do not make any recommendations in this regard. Instead, we focus on reforms in three separate areas, designed to address perceptions about the Inspector-General's independence from Defence:
- criteria for appointment of the Inspector-General
 - senior leadership positions and staffing of the Office of the IGADF
 - operational matters concerning the Office of the IGADF.
100. We also make no recommendations concerning the Inspector-General's reports to the CDF or the Inspector-General's involvement in the MJSG. However, we hope that the Inspector-General considers the issues we have identified and how these matters might affect confidence in the Inspector-General's independence.

Criteria for appointment of the Inspector-General

101. The professional background of the person who is appointed as the Inspector-General influences perceptions about the role's independence.
102. Section 110F of the Defence Act provides that a person must not be appointed by the Minister as the Inspector-General unless the person 'has knowledge of and experience in relation to military justice issues and an understanding of their relevance to the role of the Defence Force'.⁸⁰
103. The only two people to have held the role of Inspector-General role had lengthy careers in the ADF prior to assuming the position.
104. On 6 October 2005, Mr Earley was appointed as the Inspector-General by the then Minister, in accordance with section 110E of the Defence Act.⁸¹
105. On 22 December 2015, Mr Gaynor, the then Deputy Inspector-General, was appointed as the Acting Inspector-General.⁸² Mr Gaynor served in the Australian Army Legal Corps as an Army lawyer for 23 years, following which he had roles as the Deputy Director of Military Prosecutions and the Director of Military Justice.⁸³ Prior to his appointment as Inspector-General, Mr Gaynor was a Brigadier in the ADF. While Mr Gaynor ceased service when he assumed the role of Inspector-General, he has longstanding and deep connections with the ADF.⁸⁴
106. Having a person appointed as Inspector-General who has knowledge of and experience in relation to military justice issues and an understanding of their relevance to the role of the ADF are not the only criteria that might be applied.⁸⁵
107. For example, the Burchett Report identified alternatives, stating:
- [T]he appointee [to the role of Inspector-General] should have a close familiarity with the Australian Defence Force environment or should be at the apex of a highly expert staff with that familiarity. An understanding of the military justice system would be essential.⁸⁶

108. In the event, the ‘close familiarity model’ as contemplated in section 110F of the Defence Act was adopted, rather than this ‘apex model’.
109. We recognise the benefits of the Inspector-General appointee having a close familiarity with the ADF environment. It can be said that such a person knows where to look, what questions to ask, and how various matters might be approached in Defence. Mr Gaynor put it that because of his familiarity with the ADF, no-one would ever try to ‘mislead’ him.⁸⁷ However, a disadvantage of such familiarity is the apprehensions of bias that might arise because of relationships and connections formed through prior ADF service. The risk of unconscious bias is also a concern. Factors of this kind can contribute to perceptions of a lack of independence.
110. We discussed these competing considerations with Captain Shindy. She said:
- It is a really hard issue because the Defence Force and, in my case, my service in the Navy, it’s a whole different world ... [Y]ou get indoctrinated from the day you join. You become part of the mechanism of that service. You learn a whole new language. You have different education about tradition and about what’s expected, how to eat properly with a knife and fork, and the whole bit about what we do in terms of taking this individual and then making them part of a system. And it becomes part of their identity. It’s something that they love and certainly I have loved and – and feel a great loyalty to. But in that, making that person part of that mechanism, it changes the person and they – they learn a lot. You learn a lot over three decades and it’s hard to then say, well, who would be independent enough that [has] lived that system.⁸⁸
111. Captain Shindy suggested an alternative, saying:
- [M]aybe it’s a combination of, I don’t know, a board maybe, which has a number of members who have that literacy, that in-depth understanding of the culture, the operational way things work, the way decisions are made, but also has enough independent scrutinisers, people who pose the difficult questions.⁸⁹
112. Other countries have Inspectors-General of their defence force, or an office performing a similar role but with a different name. We discuss these models further in Chapter 2, Lessons learnt from overseas. Care must be taken, however, in drawing inferences from the models in other jurisdictions, because the role and functions of these Inspectors-General (or other titled positions) may not be equivalent.
113. It is apparent that there are no single consistent or accepted criteria for analogous or similar roles to the Inspector-General in other jurisdictions.
114. On balance, we consider that a person appointed to the position of Inspector-General should *not* have had a career in the ADF. This key reform is to address perceptions of the Inspector-General’s lack of independence from Defence. Having an Inspector-General who does not have established connections with Defence would enhance perceptions that the Inspector-General is independent of Defence, and the confidence of ADF members in the discharge of the Inspector-General’s functions.

115. Given the Inspector-General's functions, it may be of assistance if the person who is appointed to the role has experience and familiarity with the civilian justice system. For example, such knowledge would help the appointee advise on matters concerning the ADF military justice system and recommend improvements. However, we do not see this as a prerequisite, and there may be people with other qualifications who would also be suitable for the position.
116. We believe the 'apex model' of the kind referred to in the Burchett Report should be adopted.⁹⁰ While the Inspector-General should not be drawn from the ADF, they should be assisted and supported by two Deputy Inspectors-General who have appropriate skills and experience, for example, having served in the ADF or having experience and understanding of the justice system, including military justice. If they are serving members, they should resign their commissions and cease service upon appointment.
117. The two Deputy Inspectors-General should each have responsibility for the operations of certain directorates in the Office of the IGADF, and the directors of the directorates should report to them. In our view, it would be preferable if the Deputy Inspectors-General were, like the Inspector-General, statutory appointments.

Senior leadership positions in the Office of the IGADF

118. In section 12.2.2, we discuss the limited ability of the Inspector-General to select the people seconded from the ADF to the Office of the IGADF, including people in senior leadership positions such as directors of the office's directorates.
119. The Inspector-General's inability to select ADF members they believe are best suited to discharge the functions of the Office of the IGADF impedes the Inspector-General's authority, and compounds perceptions that they are not sufficiently independent of the ADF.
120. In section 12.2.2, we noted that Mr Gaynor is taking steps to try to address this, such as by running his own selection process for senior positions in future. We understand this has been agreed to by the CDF.⁹¹ He is also expanding the pool from which he recruits.
121. As referred to in section 12.2.2, Mr Gaynor has decided to 'civilianise' the position of Director of the DSIR. Despite the fact that the Director of the DSIR has been a senior ADF legal officer (at the level of captain in the Navy, colonel in the Army or group captain in the Air Force), Mr Gaynor had determined to create a director-level position in the public service for the Director of the DSIR.⁹²
122. Mr Gaynor said that a reason for making this change was a desire to encourage continuity in the role, so that the selected director will be able to fill the role for longer than a posting cycle, and therefore longer than the two previous incumbents.⁹³ Some additional reasons were outlined in the relevant Noting Brief for the CDF.⁹⁴ Further, Mr Gaynor said that this change would mean that he could choose a director who is not necessarily a lawyer.⁹⁵

123. Mr Gaynor told us that the recruitment process for the new director was ‘open’ and not confined to Department of Defence APS staff, nor to people currently working in the APS.⁹⁶
124. We note in passing that there seems to have been an assumption that because a person is a senior legal officer in the ADF, they have the skills and competencies to be the Director of the DSIR. Any such assumption seems to us difficult to justify.
125. In our view, the ability of the Inspector-General to select the senior staff in their office is critical. Without the Inspector-General having the power to scrutinise those key officeholders in the Office of the IGADF – including for their apparent willingness, where necessary, to disagree with the views of the ADF – there is at least a further risk of undermining confidence in the independence of Office of the IGADF staff.

Staffing of the Office of the IGADF

126. As we have explained, the composition of the Office of the IGADF workforce is heavily skewed in favour of ADF permanent members and reservists.
127. Mr Gaynor gave evidence that there were ‘good reasons’ for using ADF permanent members and reservists to perform the Office of the IGADF’s functions.⁹⁷ With respect to the DSIR, he said:

[I]n order to undertake any inquiry in the Defence environment, it is very useful to have a knowledge and awareness of – of that environment, as well as of the ... ADF members who are likely to be witnesses in an inquiry into a service death.⁹⁸

128. We acknowledge the usefulness of military experience and knowledge in discharging the Inspector-General’s functions. However, to address concerns about perceptions of independence, it would help if there were less reliance on ADF permanent members and reservists in the staffing of the Office of the IGADF. This is particularly so for the DSIR, DMRR and DII, which deal with inquiries and complaints. Perceptions of independence would also be improved if it were clearer that staff who are not ADF members and reservists manage matters handled through these directorates.
129. Since Hearing Block 11, we have been told that there are now more APS personnel than ADF members in the full-time staff of the Office of the IGADF.⁹⁹ This is a positive development. The Inspector-General should also seek to have more people who are not ADF reservists appointed as Assistant Inspectors-General to discharge those functions managed by the DSIR, DMRR and DII. Of course, non-military Assistant Inspectors-General can, and likely should be assisted by Office of the IGADF staff seconded from the ADF.
130. We acknowledge that recruiting additional personnel with appropriate qualities, professional qualifications and technical skills will be challenging and may take time.

131. We do not see it as essential that ‘civilianising’ the Office of the IGADF should be limited to recruiting staff made available by the Secretary of the Department of Defence. Nor do we see it as essential that those recruited have experience in the ADF. In our view, the Inspector-General should be able to recruit from outside the ADF and the APS, and have the funding to do so.
132. The need for this flexibility is apparent given the evidence we have heard regarding problems finding staff for the Office of the IGADF.
133. In a report to the Vice Chief of the Defence Force in October 2023, the Inspector-General said that staffing was an issue that reduced his ability to perform his military justice functions efficiently and effectively. He wrote:

[the] services have been unable to fill some positions which are gapped or addressed by part-time remote workers which is not optimal; in other cases, staff have been found to lack the specific skills and resilience leading to unplanned and extended absence and early posting (without relief).¹⁰⁰

134. In a Noting Brief to the CDF in April 2023, the Inspector-General said:

There is no lack of financial resources but finding appropriately qualified and experienced inquiry staff remains challenging. Although we are continuously improving inquiry processes and exploring efficiencies, this lack of suitable inquiry resources is having an inevitable impact on timeliness.¹⁰¹

135. Mr Gaynor told us that this brief referred to staffing in the DSIR and DII.¹⁰² He also said that finding ADF personnel, particularly reservists, for inquiry work has been very challenging, and that because the services have established inquiry teams themselves, they effectively compete with him for staff.¹⁰³

136. The Deputy Director of the DSIR highlighted the staffing problems in that directorate, saying:

[C]ontinuity of staffing has been an issue both within my tenure but anecdotally, I understand, prior to my tenure. I appreciate that many workplaces have to shoulder staffing vacancies and a lack of continuity but I think when you have a directorate that is inquiring into the deaths of service members, our workplace is less able to sustain staffing issues for a protracted period of time. So that’s the first systemic issue that I see being relevant to the directorate.¹⁰⁴

137. In relation to finding reservists to conduct inquiries as Assistant Inspectors-General, the Director of the DII said:

Oh, it’s incredibly challenging. I find that the pool of [reservist] individuals who have a combination of technical and people skills that would be ideal to work for us are also in high demand for employment in other areas and it is very difficult to attract and retain those people.¹⁰⁵

138. The Director of the DII acknowledged that the directorate was inadequately staffed, saying:
- I think we definitely need a number of additional staff. I think that the – the case management that we do of our matters demonstrates that we still have matters that are not proceeding because of a lack of resources to move matters to their next stage. So definitely additional resources would be very useful ... I think, personally, that more permanent staff would be the best solution.¹⁰⁶
139. The Director of the DMRR told us that he had multiple positions established and funded in his directorate, but that were vacant because the services were unable to post suitable people to them. He recognised that recruiting from outside of Defence might be a way of addressing the problem.¹⁰⁷
140. Insufficient resourcing was an issue we heard about consistently in relation to the Office of the IGADF. It is clear that more personnel are needed. This is not only to change the balance of staffing so there is less reliance on reservists, but also to enable the Inspector-General's functions to be discharged.
141. As outlined in this chapter, there are also several ways the Inspector-General's work could be expanded, and the Office of the IGADF will need additional staff if that work is to be done.
142. In our view, a detailed study into the overall resourcing needs of the Office of the IGADF should be conducted and a workforce plan that outlines both the numbers of personnel needed and their required skills and qualifications developed. This should be done as soon as possible.
143. The Inspector-General has power to engage consultants under section 110O of the Defence Act. However, the Inspector-General would be assisted in meeting staffing requirements if section 110O were amended so that the Inspector-General is not limited to members of the ADF made available by the CDF and APS personnel made available by the Secretary of the Department of Defence.
144. The Australian Government should do all it can to enable an increase in, and rebalancing of the workforce of the Office of the IGADF as we have outlined, including by making funding available for staff positions and amending section 110O of the Defence Act.
145. It is our view that the Inspector-General should seek to reduce reliance on ADF reservists as Assistant Inspectors-General tasked with discharging the functions of the Inspector-General managed by the DSIR, DMRR and DII.

Guidance on processes and policy

146. In this chapter, we discuss guidance or standard operating procedures concerning the discharge of the Inspector-General's functions by the DSIR, DMRR, DMJPR and DII, the processes the directorates apply, and the way in which the Inspector-General's powers are exercised. We also refer to gaps in the documented processes of specific directorates.
147. Prior to 2022, it does not appear that there was comprehensive guidance in the DSIR, and the evidence we heard was that there was no comprehensive guidance in the DMRR at all.
148. There was comprehensive guidance in the DMJPR. In relation to the DII, the Director of the DII set about compiling comprehensive guidance when she joined the directorate in 2019.
149. Comprehensive guidance, including as to quality assurance processes, is necessary to support the discharge of the Inspector-General's functions by these directorates.
150. In our view, it would also improve perceptions of the Inspector-General's independence if comprehensive guidance or standard operating procedures for each of the DSIR, DMRR, DMJPR and DII were made available to ADF members and the public on the Inspector-General's website. This would improve transparency about how the functions are discharged, and ADF members and others would better understand what to expect and what should occur in their engagement with the Inspector-General. Having comprehensive, publicly available guidance in relation to each of these directorates would also enhance governance.

Other actions

151. There are other actions that should be considered to address perceptions that the Inspector-General is not sufficiently independent of Defence.
152. For example, the Inspector-General should avoid co-branding correspondence with Defence. As the Director of the DMRR told us, in letters that include information on ROG outcomes, they aim to avoid any such co-branding to avoid the perception that the Inspector-General is an inherent part of Defence.¹⁰⁸
153. It would also be preferable if, to the extent practicable, the Inspector-General were to have its physical offices in locations that are not Defence premises.

12.3 The DSIR: inquiring into the deaths of ADF members

154. A key responsibility of the Inspector-General is to inquire into the deaths of ADF members, where the death appears to have arisen out of, or in the course of, a member's service. This includes deaths by suicide.¹⁰⁹
155. Inquiries are a critical opportunity for contributing factors to individual suicides to be identified, and for common themes, trends and systemic issues to be analysed.
156. As discussed in this section, reforms are required to the way in which this function of the Inspector-General is discharged where deaths are suspected suicide.

12.3.1 Overview

157. Inquiries into the deaths of ADF members used to be conducted in Defence as a 'Chief of the Defence Force Commission of Inquiry' under the *Defence (Inquiry) Regulations Act 1985* (Cth). However, responsibility transferred to the Inspector-General in 2014, and the function was incorporated in the IGADF Regulation in 2016.¹¹⁰
158. ADF members for this purpose include members of the permanent forces (SERCAT [service category] 6 and 7), and ADF reserve members (SERCAT 2 to 5). These SERCATs cover:
 - (1) a member of the permanent/regular forces (SERCAT 6 and 7)
 - (2) a member of the reserve forces on continuous full-time service (SERVOP [reservists rendering full-time service] C available to SERCAT 3 to 5)
 - (3) a member of the reserve forces who holds SERCAT 4 or 5 under which members provide capability at short notice, or are provided a minimum number of days of service, and are required to meet individual readiness obligations and training standards
 - (4) a member of the standby reserves who was not obligated to render military service but whose death may have arisen from causal factors occurring in an earlier period when they were rendering service (SERCAT 2).¹¹¹

159. Inquiries into deaths of ADF members serve a number of important purposes:
- For the ADF, they provide an opportunity to understand why the death has occurred, to ascertain whether any systemic issues are involved, to receive findings and recommendations, and to take actions to prevent similar deaths occurring in the future.
 - For family members, partners and loved ones, they serve to provide answers in relation to the death of their loved one, which may greatly assist in the grieving process and in dealing with the trauma of the death.
 - For commanders, they can provide valuable lessons learnt that may assist them to do things differently at an individual, unit or base level, so as to reduce the likelihood of future occurrences.
 - For colleagues, they can aid closure and help them deal with the loss by providing an understanding of what happened.
160. Inquiring into deaths of members by suicide can be complex, given the many factors, and the different kinds of factors, that might have contributed to the death, the personal nature of suicide, and the need for the best answer possible to the critical question: Why did it happen?
161. Inquiring into the death of an ADF member can be challenging for all involved – for family members and loved ones, for colleagues who knew the deceased, and also for those conducting the inquiry. We also recognise the magnitude of the task. In the 2021–22 financial year, the Inspector-General was notified of and commenced inquiries into 36 deaths of ADF members, of which 16 were suspected suicide.¹¹² In the same year, it finalised 32 inquiries, five of which were determined to be deaths by suicide.¹¹³ As at July 2023, the Office of the IGADF had 57 open inquiries into deaths of serving members. Twenty-three of those concerned death by suspected suicide.¹¹⁴
162. We acknowledge that such inquiries are heavy tasks and recognise the valuable work of those in the Office of the IGADF that undertake them. However, we have found a number of issues in relation to the discharge of this function. In this section, we identify these issues and present options for reform.

12.3.2 The DSIR

163. The Inspector-General is supported in the function of inquiring into the deaths of ADF members by the DSIR.
164. The directorate has a Director and a Deputy Director. However, as at September 2023, the Deputy Director, Lieutenant Colonel Damien Spendelove, was acting Director of the DSIR, a role he had assumed in June 2023.¹¹⁵ This was due to the absence of the incumbent Director, with the Director role otherwise being vacant.¹¹⁶

165. We were told that the DSIR had eight permanent staff at that time. In addition to the Director and the Deputy Director, both of whom were on postings from the ADF, there were four other ADF officers, and two administrative personnel at the APS6 and APS4 levels.¹¹⁷
166. In addition to the permanent staff, the DSIR relies heavily on ADF reservists to assist in the conduct of inquiries. The DSIR does not have specific ADF reserve officers allocated to it, but rather identifies reservists to assist with inquiries on an 'as-required' basis.¹¹⁸ The DSIR draws these reservists from a pool of about 30 ADF reserve officers that is shared between the DSIR and the DII.¹¹⁹
167. The DSIR has faced staffing challenges in recent years. We were told that since November 2022, an external law firm had been engaged to supplement the DSIR's workforce and assist with the directorate's caseload.¹²⁰
168. DSIR permanent staff, ADF reserve officers, and consultants engaged to assist the DSIR are appointed as Assistant Inspectors-General for the purposes of discharging the functions of the Inspector-General.¹²¹
169. The Deputy Director told us that 'capacity issues and some staffing issues' had impeded the directorate's ability to undertake work.¹²² Mr Gaynor told us that there had been challenges with some staff and said that the DSIR was a directorate without a director that had been through a 'significant period of stress'.¹²³
170. In section 12.2.2, we discussed the position of the Director of the DSIR, and the recruitment process the Inspector-General was undertaking to 'civilianise' it.

12.3.3 The DSIR's processes

171. The standard guidance for the DSIR is contained in the *DSIR Guidance Manual for Standard Operating Practices* (the Guidance Manual), which is dated 29 November 2022.¹²⁴
172. The Deputy Director told us that when he arrived at the DSIR in March 2022, there was very little structure and process in the directorate as far as he could see. He said that what held the directorate back was having to clear the backlog of inquiries together with managing what he referred to as 'normal workflow', at the same time as having to 'set up structure[s] and process[es] almost from scratch'.¹²⁵
173. While there were forms of guidance in place since 2016 in respect to the conduct of inquiries into the deaths of ADF members – including in written directions for individual inquiries – the Guidance Manual appears to contain more comprehensive standard operating procedures for conducting inquiries into the deaths of ADF members than previously existed.

174. According to the Guidance Manual, there are four phases to the DSIR inquiry process in relation to deaths of ADF members:
- the Preliminary Phase
 - the Assessment Phase
 - the Inquiry Phase
 - the Case Closure Phase.¹²⁶
175. The four phases are set out in a DSIR process map, which is an enclosure in the Guidance Manual.¹²⁷
176. The Guidance Manual recognises the complexity of inquiring into the death of an ADF member:

The inherent complexity of inquiring into service-related deaths is compounded by a number of factors, such as: the different state or territory jurisdictional considerations on death; the need to communicate compassionately and transparently with the deceased member's family. Discretion, balance and a deliberate approach must be exercised with each component of the DSIR process. Although there may be discrete phases for each part of the DSIR process, there is continual overlap of mutually supporting DSIR capabilities, which include: coordination, case support, external stakeholder and, where applicable, inquiry capabilities.¹²⁸

The Preliminary Phase

177. The purpose of the Preliminary Phase is:

to collect readily available information from relevant authorities, both internal and external to Defence, to enable the IGADF to exercise their legislative function to assess and inquire into the death of an ADF member ... While information gathering continues throughout the DSIR process, the information gathering undertaken during the Preliminary Phase is an essential step in informing each of the subsequent phases in the DSIR process, but particularly the Assessment Phase.¹²⁹

178. The main sources of information are Joint Health Command, coroners, service documentation and records, Defence Member and Family Services, the Joint Military Police Unit and civilian police reports and statements, Comcare, next of kin and family members, the deceased member's unit and Department of Veterans' Affairs.¹³⁰

179. Joint Health Command information consists of a review of the deceased member's medical and psychology files undertaken by the Director of Strategic Clinical Assurance and Ethics (DSCAE). According to the Guidance Manual:

[the DSCAE] is a medical authority reporting to the Chief of Joint Health, but who is separate to Garrison Health Branch and not involved in the provision of health services to ADF members. The independence of DSCAE from the provision of garrison health services enables the conduct of an impartial medical review that informs, in particular, the subsequent Assessment Phase and Inquiry Phase (if the latter phase is required).¹³¹

180. In relation to coroners, the types of information that may be obtained include post-mortem, toxicology, autopsy, preliminary or external medical examination, and police coronial support unit reports.¹³²

The Assessment Phase

181. According to the Guidance Manual, the Assessment Phase:

commences when sufficient information collection has occurred during the Preliminary Phase to enable an 'on the papers' understanding of the circumstances of the death of an ADF member ... The level of information required to commence the Assessment Phase will vary depending upon the nature of the case.¹³³

182. It is noted that 'while deaths by illness (i.e. natural causes) may require less information, deaths by suicide will normally require a substantially higher level of information before conducting an assessment', such as requesting police statements or a post-mortem report from a coroner.¹³⁴
183. The purpose of the Assessment Phase is to determine whether there is jurisdiction to conduct an inquiry under section 5(a) of the IGADF Regulation, and if there is jurisdiction, whether the Inspector-General should exercise their discretion to conduct a lengthier inquiry. This more formal inquiry would be conducted under written directions so as to reliably inform any recommendation on whether remedial or other appropriate action should be taken.¹³⁵
184. As already noted, whether the Inspector-General has jurisdiction to conduct an inquiry depends on whether the death of the member appears to have arisen out of, or in the course of, the member's service – that is, whether there was a 'service nexus'.

Determination of service nexus

185. Determining whether the death of a serving member has a service nexus can be challenging.

186. The Guidance Manual provides general guidance as to the determination, and this is supplemented by a memorandum of legal advice and another internal advice.¹³⁶ The test of service nexus is a legal one.

187. The Guidance Manual says:

- (b) **'Appears'**. As the test is for the purpose of determining whether there should be further inquiry, it is appropriate to conduct a review based on appearance, rather than conclusively established facts. This is intended to apply the most favourable consideration to the relevant matter. This does not mean, however, that at the time of conducting an assessment the test can be met by unfounded suspicion, or where there is sufficient, reliable evidence against what 'appears' to a particular observer. In all circumstances, a review should be conducted on a reasonable view of the available information.
- (c) **'To have arisen out of the member's service'**. This limb in section 5(a) is referred to as the causal test. How this analysis is approached to establish IGADF's jurisdiction to inquire into a death will vary according to the nature of the circumstances of the death or the service categories listed above. In satisfying the causal test the connection between the ADF member's death and their service does not have to be the 'sole, dominant, direct or proximate' connection or cause. However, generally speaking, the ADF member's service must be a contributing and not a remote causal factor.
- (d) **'To have arisen in the course of the member's service'**. This limb in section 5(a) is referred to as the temporal test, which is not always confined to establishing that an ADF member was on duty, or not, at the time of their death. For example, if the member was engaging in his or her duties or other activities, which may be reasonably regarded as part of his or her service, or if the member was at a place to perform his or her duties, or was travelling for the purpose of performing those duties, the test may be met. In cases where the death of an ADF member has occurred in an interval or interlude during an overall period of work or duty, to meet the temporal test it is a relevant consideration whether the circumstances of the death are connected to an inducement or encouragement by Defence. If the death occurs while engaged in an activity at a certain place, that connection does not exist merely because of an inducement or encouragement to be at that place. The relevant question is: did the employer induce or encourage the employee to engage in that activity?

Irrespective of whether or not the temporal test is regarded as being satisfied in a death by suicide case, the causal test is regarded as having far greater relevance.¹³⁷

188. Much is left to the judgement of DSIR staff in determining whether a service nexus exists. The circumstances may be complex, particularly in cases of suspected deaths by suicide, where there can be many factors involved. Determining what those factors were, and whether they related to the member's service, can require a sophisticated, detailed examination.
189. According to the Guidance Manual, in cases where no service nexus is found, this does not preclude recommendations of remedial or other action being made.¹³⁸

The Inquiry Phase

190. On the Inquiry Phase, the Guidance Manual specifies:

Where the outcome of the Assessment Phase is that a lengthier, more formal inquiry is required, the IGADF... will normally issue Directions ... to an Assistant IGADF. The Director and staff members of the DSIR team have extant appointments as Assistant IGADF, and DSIR team members support the Director in their oversight and management of IGADF inquiries into service deaths.¹³⁹

191. Formal inquiries are conducted by Assistant Inspectors-General appointed under written directions issued by the Inspector-General or an authorised delegate. An Assistant Inspector-General is expected to observe and apply the standing instructions contained in an enclosure to the Guidance Manual.¹⁴⁰ The standing instructions cover a range of matters, including that the inquiry is to be conducted in private and that evidence may be taken on oath where necessary. They also set out requirements for procedural fairness, the making of recommendations, and legal support for witnesses and the deceased member's interests.
192. An important element of the Inquiry Phase is the provision of a draft of the inquiry report to the deceased member's next of kin for input prior to the report's finalisation.¹⁴¹ We address aspects of this engagement in section 12.3.8.
193. Once an inquiry is complete, the Guidance Manual states that the report is to be submitted to the Director of the DSIR for review. Once satisfied with the report, the Director then submits the report to the Deputy Inspector-General and the Inspector-General for their signatures.¹⁴² The report is then forwarded to the CDF through ADF Headquarters (ADFHQ).¹⁴³
194. ADFHQ manages the implementation of findings and recommendations from Inspector-General reports concerning the deaths of ADF members.¹⁴⁴ As the Vice Chief of the Defence Force told us, the Inspector-General's reports 'are provided to the CDF, and the ADF Headquarters supports the CDF in reviewing and the implementation plans associated with those reports from the IGADF'.¹⁴⁵
195. On occasion, ADFHQ may seek further information from the Inspector-General.¹⁴⁶

The Case Closure Phase

196. During the Case Closure Phase, the final version of the report is drafted and the report is signed by the Inspector-General or an authorised delegate and forwarded to the CDF through ADFHQ under a covering minute or letter.¹⁴⁷
197. Key aspects of the Case Closure Phase are the provision of the final report to the next of kin of the deceased member, and a debriefing of the family. These aspects are discussed further later in this section.

12.3.4 When suicide is suspected, the DSIR now follows a different process

198. Significantly, there has been a change in the DSIR's approach where a death of an ADF member is by suspected suicide.
199. Where suicide is suspected, the separate initial Assessment Phase focused on whether there was a service nexus has been largely superseded, with all deaths by suspected suicide now proceeding to a formal inquiry under written directions. Service nexus is determined at the conclusion of the formal inquiry.¹⁴⁸
200. For suspected deaths by suicide, the Assessment Phase is concerned with determining the scope of the matters to be inquired into in the formal inquiry.
201. The Guidance Manual has incorporated passages that reflect this approach:

[14] ... at the outset it is important to note that the Assessment Phase will be different depending upon the category of death under consideration ... Due to the multi-dimensional nature of causal factors commonly associated with deaths by suicide, a more formal inquiry will almost always be required to ascertain both whether the death was service related and whether recommendations are open to prevent similar service deaths in the future. The Assessment Phase in relation to deaths by suicide will normally involve considerations relating to the scope of matters to be inquired into, which will inform the inquiry directions, and identifying appropriate Assistants IGADF to conduct the inquiry ...

[15] ... In relation to a death by suicide, however, the IGADF inquiry report will be provided to CDF following a lengthier, formal inquiry under directions issued by the IGADF (or under an authorisation). As indicated above, due to the nature of deaths by suicide it will most often not be apparent whether a death was service related until after the inquiry is complete. For that reason, the jurisdictional question of whether a death is service related will always be reflected at the conclusion of the inquiry, in the inquiry report, together with any recommendations arising ...¹⁴⁹

202. This approach to suspected suicides differs significantly from what occurred previously, where initial assessments focused on service nexus were conducted on the basis of the information gathered in the Preliminary Phase.
203. As the Deputy Director put it, prior to his joining the Office of the IGADF in 2022, a 'different process' was followed by the DSIR in relation to suicides, which involved 'an initial Assessment Phase directed at the test of [the death] arising out of, or in the course of, a member's service'.¹⁵⁰ He further said that 'some of these [assessment] reports appear to have been done as desktop reviews'.¹⁵¹
204. Mr Gaynor said that:
- for some years now, my office has produced an inquiry report in connection with suicides, whereas, previously, the office would produce ... almost an administrative document that assessed jurisdiction.¹⁵²
205. The previous approach often resulted in an Assessment Report concerning the death based solely on information gathered in the Preliminary Phase, with a single finding that there did not appear to be a service nexus, and a recommendation that no further inquiry into the circumstances of the death was required.
206. In 2022, Select Strategic Issues Management (SSIM) in ADFHQ produced 'Assurance Check Report 22-04'.¹⁵³ Assurance Check Report 22-04, which was prepared at the CDF's direction,¹⁵⁴ comprised a non-technical analysis of 59 reports by the Inspector-General dated between 1 June 2016 and 30 June 2022 that concerned the deaths of 57 ADF members where the deaths were or may have been by suicide. Assurance Check Report 22-04 notes that 41 of the Inspector-General's reports had only one finding (related to service nexus), and 43 of them only had one recommendation (that no further inquiry was required).¹⁵⁵
207. Witnesses from ADFHQ told us that because the reports subject to Assurance Check Report 22-04 were an initial inquiry into service nexus, they tended to be limited in detail unless service nexus was ascertained, in which event reports might be more detailed to determine what aspects of nexus contributed to the death of the member. One of the witnesses further said that because the purpose of the reports was to look broadly at whether there was a service nexus, that shaped the information included in the reports and the scope of the reports themselves.¹⁵⁶
208. Many Inspector-General reports produced to us dated from 2016 and concerning the deaths by suicide of ADF members are Assessment Reports of this kind. They are sometimes only a handful of pages long, and primarily focus on whether there was a service nexus in relation to the death rather than necessarily including a broader analysis and consideration of the immediate and underlying factors that may have contributed to the death by suicide. Examples of these kinds of reports were discussed in Hearing Block 11.¹⁵⁷

209. This is not to say that all Assessment Reports were limited in detail. Some were lengthy and contain detailed analysis. The Inspector-General referred us to eight such reports dated between 2016 and 2019.¹⁵⁸ In these reports, one of which was not an inquiry into the death of the member, there were directions and findings in addition to service nexus, which concerned specific issues that had been raised or identified relating to the member – for example, allegations of unacceptable behaviour towards the member and actions taken in response, the medical treatment provided to the member, welfare support provided to their family and so on.
210. The Deputy Director told us that the change in approach began shortly before he joined the DSIR in March 2022,¹⁵⁹ and that he ‘followed the higher guidance ... [of] what [he] understood was the intent of the IGADF’.¹⁶⁰ He also said the change was something that had ‘been consistent with and commensurate with the work of the Royal Commission’.¹⁶¹
211. According to Mr Gaynor, the approach changed from about the beginning of 2020,¹⁶² and this change occurred because he became aware that the reports being produced by the DSIR were not just reports to the CDF in accordance with legislation, but were for other interested groups and, most importantly, next of kin and families. He said that the reports of the inquiries were important for next of kin and families because, in many cases, they were the last or only official record of their loved one’s circumstances and death.¹⁶³
212. We fully endorse these observations by Mr Gaynor as to the importance of the Inspector-General’s reports, and the importance of comprehensive reports to next of kin and family members. We also consider that the new approach should further increase the depth of detail and analysis that typically occurs where suicides are concerned.
213. The change in approach with service nexus not being determined as an initial matter is reflected in recent Inspector-General reports concerning suspected suicides. They are substantial pieces of work, and many contain a significant number of recommendations.
214. This is consistent with evidence given to us by Colonel Michelle Mason of ADFHQ. She told us that in ADFHQ they looked back at Inspector-General reports from 2017, and that there were not as many recommendations to implement as there are now, and reports now contain far more recommendations than they used to.¹⁶⁴

215. The Deputy Director told us that the phases have been renamed to reflect the DSIR's new approach in relation to deaths by suicide.¹⁶⁵ He said that the phases where suicide is involved are detailed in an updated process map,¹⁶⁶ and are:

- the Preliminary Phase (the gathering of information)
- the Inquiry and Report Writing Phase
- the Review Phase
- the Case Closure Phase.¹⁶⁷

216. The updated process map was not included in documents produced to the Royal Commission.

217. The Deputy Director described the written directions that are issued to an inquiry team to assist an Assistant Inspector-General with the formal inquiry in relation to a death by suicide. He said:

Those directions will also specify issues to which the inquiry team needs to turn its mind. So those will be whether there were any acts or omissions on the part of the ADF or Defence that may have contributed to the member's death. Inquiry teams will also be specifically directed to address whether there were any ... suicide risk factors. They will also be specifically directed in the directions to consider whether there is any policy or ADF or Defence policy or procedural issues that may have contributed to a member's death. The directions will also specifically direct the inquiry team to engage with the next of kin for the purpose of assisting them with those lines of inquiry.¹⁶⁸

218. We fully support the approach now being followed by the DSIR in relation to inquiries concerning deaths of ADF members by suicide or suspected suicide. Proceeding in all cases to a formal inquiry under written directions can only enhance the investigation that is conducted and the usefulness of the reports produced. They will also better meet the needs not only of the CDF, but also of the next of kin and family members, as Mr Gaynor identified.

219. The current approach will likely enhance the depth and rigour with which critical issues are considered, including:

- whether the death was by suicide, even though the immediate circumstances might mean that the death is not obviously by suicide (such as an accident involving a single motor vehicle)
- the contributing factors to the suicide
- whether the death by suicide was related to the member's service, including where service might be the underlying reason for immediate factors such as relationship breakdowns or family issues, depression, stress, post-traumatic stress disorder, or drug or alcohol dependency.

220. As the Deputy Director conceded, the question of whether service-related issues might have contributed to relationship breakdowns was not a focus in the reports he had seen that had been written before he joined the DSIR in March 2022.¹⁶⁹
221. Conducting formal inquiries under written directions should also lead to more recommendations being made in relation to deficiencies of policy and process, and on the subject of individual accountability.¹⁷⁰
222. It is concerning, however, that when the Deputy Director gave evidence on 31 August 2023, the revised process for inquiring into deaths of ADF members by suicide had not already been fully codified in the standard operating procedures of the DSIR.
223. The Deputy Director told us that it will be codified as soon as is practicable, but that this was being held up by capacity and staffing issues in the DSIR.¹⁷¹
224. It was subsequently suggested to the Royal Commission that because there were only eight permanent DSIR staff, it has not been necessary to codify the changed practice as the position is ‘well understood in the office’.¹⁷² We disagree: staff working on inquiries are not only the permanent staff; there is turnover; and there have been issues at the director level. All these factors mean it is not safe to entrust matters as important as the changed practice to common understandings.

Issues with the new approach to suicides

225. While we encourage the current practice in relation to inquiries into deaths by suicide or suspected suicide, it does raise some issues.
226. The first is a jurisdictional one. Taking a formal inquiry approach to a suspected death by suicide may mean that a formal inquiry under written directions is fully undertaken, only for it to be determined that the death did not arise out of, or in the course of, the member’s service. This sits uncomfortably with the language of section 5(a) of the IGADF Regulation, which gives the Inspector-General jurisdiction to inquire into a death only where there appears to be a service nexus.
227. The Deputy Director said that service status was reason enough for an inquiry to take place. He said:

I think I would rationalise it, as the deputy director ... that the person’s service status as a service category 2 to service category 7 member is enough for us to at least meet a jurisdictional threshold that the person’s service may have contributed to the person’s death by suicide, and that’s the way we pragmatically I think, are applying that limb of the test.¹⁷³

228. Mr Gaynor rationalised it this way:

A. ... I wouldn't say we do it without a jurisdictional threshold ... because we rely very much on the word 'appears' in section 5 ...

Q. But there may be a circumstance in which you complete a full inquiry and the conclusion of that full inquiry is that the service nexus in section 5(a) is not reached.

A. Yes, but at that moment, we will know that the death no longer appears to have arisen out of; we'll be able to say it didn't arise out of or in the course of service.¹⁷⁴

229. In our view, these explanations are not entirely satisfying, but the current practice is not to be discouraged.

230. The Deputy Director said that in his view, section 5(a) of the IGADF Regulation should be amended to make it more closely align to the current practice, and Mr Gaynor said he could see benefit in making the legislation clearer.¹⁷⁵ We agree.

231. The second issue is that the new approach of the DSIR applies where suicide is suspected. However, whether a death is or may be by suicide is not always readily apparent, for example, in the case of an accident involving a single motor vehicle or death by drug toxicity.

232. We expect that in determining whether the new approach should be followed in a given case, a broad view will be taken as to whether a death may be by suspected suicide. Subject matter expertise should also be obtained, as discussed in section 12.3.5.

12.3.5 DSIR staff skillsets

233. The DSIR's workforce is comprised largely of lawyers and staff with legal qualifications.

234. Of the eight permanent members of the DSIR, five have legal backgrounds.¹⁷⁶ Most of the reservists used by the DSIR as Assistant Inspectors-General for inquiries are lawyers, with a number having had experience as prosecutors or in Department of Public Prosecutions offices.¹⁷⁷ We have already noted that the DSIR is being assisted with its caseload by an external law firm as consultants.

235. There are also some permanent and reservist staff of the DSIR who have policing backgrounds, and several staff members with experience in coroners' offices.¹⁷⁸

236. While legal expertise is undoubtedly a relevant capability for the DSIR, it should not be assumed that because someone is a lawyer, they are best able to conduct an inquiry into the death of an ADF member, including a death by suicide.

237. Given the nature of the Inspector-General's function, in our view there should be a greater emphasis on staffing the DSIR with people with policing and other investigative or forensic backgrounds, as well as people with relevant coronial experience. This is particularly the case with Assistant Inspectors-General.
238. Having more staff with these different capabilities and skillsets would likely improve the quality of the inquiries undertaken, particularly in the context of suicides, where the issues under consideration may be complex.
239. These staffing needs must be taken into account as part of the broader considerations about the staffing of the Office of the IGADF that we discussed in sections 12.2.3 and 12.3.2.
240. Another factor to be considered in staffing the Office of the IGADF is the inevitable disadvantage of having ADF staff who are on a posting cycle. It is to be expected that time is needed before an officer who is posted to the DSIR becomes familiar with the position and the requirements of the role. Yet shortly after that, they are posted back to the ADF, and the experience they have acquired is lost.
241. For this reason, in addressing staffing issues, it would be ideal if a greater proportion of DSIR staff were *not* drawn from the ADF.
242. There is also the matter of training.
243. We have been told that Office of the IGADF staff undergo general training in relation to conducting inquiries, including through the Advanced Inquiry Officer course, which is provided by the Military Law Centre within Defence. The course is designed for ADF and APS personnel who are likely to conduct an inquiry pursuant to the IGADF Regulation, or in Defence under the *Defence (Inquiry) Regulations 2018* (Cth).
244. We have not, however, been able to identify specific training for DSIR staff in relation to inquiries concerning deaths of ADF members, including by suicide.¹⁷⁹ These inquiries are not the same as other inquiries conducted by the Inspector-General. They require particular skills and competencies due to the many factors that can contribute to death by suicide, and the requirement to engage with great sensitivity with next of kin and family members who are grieving the loss of a loved one.
245. We acknowledge that in many cases, individual DSIR staff members have career-specific training and other training tailored for their professional backgrounds that is relevant. However, this is not the same as training that specifically equips staff to conduct inquiries of the kind conducted by the DSIR, covering all elements of the inquiry and report writing process.
246. The Inspector-General should introduce such training for DSIR staff.
247. Training in relation to trauma-informed practices is discussed in section 12.3.8.

12.3.6 Subject matter expertise

248. Determining whether a death may have been by suicide, identifying contributing factors, and assessing whether there is a service nexus can be a complex task. Deaths that do not immediately appear to be by suicide may, with expert analysis, be determined to be so. Immediate contributing factors to or circumstances of the death – for example, relationship breakdowns, drug dependency and overdose, stress and post-traumatic stress disorder – may in fact be related to service, even though this might not be readily apparent.
249. The subject matter expertise of a psychologist or other qualified mental health expert would assist when analysing and considering the following critical matters:
- the cause of death, and whether it may have been, in fact, suicide
 - the contributing factors to the death by suicide, including workplace and psychosocial factors
 - whether the death by suicide was related to the member's service
 - the findings and recommendations that should be made in the report.
250. Yet there is no requirement in the Guidance Manual for input from a psychologist or other mental health expert as part of the DSIR inquiry processes into deaths of ADF members.¹⁸⁰
251. The only medical input that is required to be obtained is the 'on-the-face review' of the deceased member's medical and psychological files by the DSCAE as part of the Preliminary Phase. This review does not extend beyond the deceased member's medical and psychology files.¹⁸¹
252. There is no dedicated psychologist or other mental health professional on the staff of the DSIR. We were told that the only current member of staff with a health background is a lieutenant-colonel posted to the DSIR who is a nursing officer.¹⁸²
253. We were also told that there are two welfare officers who are reservists, one of whom is a clinical psychologist and the other an organisational psychologist, with whom the Office of the IGADF consults to provide advice to and support the Office's directorates in conducting inquiries and other processes.¹⁸³
254. However, the Deputy Director told us that he was only aware of one welfare officer – the clinical psychologist – and that this psychologist is used as an internal resource to support staff welfare in the Office of the IGADF,¹⁸⁴ as opposed to providing subject matter expertise to an inquiry.
255. Mr Gaynor conceded that the clinical psychologist does not 'routinely' provide expert advice on inquiries in member deaths, for example, on whether a death was by suicide, whether there was a service nexus, or the recommendations that might be made in a report.¹⁸⁵

256. The Deputy Director told us that inquiry teams would be assisted by medical expertise, such as from a mental health expert, particularly in ‘appropriate and complex circumstances’.¹⁸⁶ Both he and Mr Gaynor said that such input can be sought as required.¹⁸⁷
257. The obvious problem, however, is that whether this input is sought depends on an inquiry team or Assistant Inspector-General recognising the need for subject matter expertise, and taking steps to obtain it.
258. The Deputy Director could recall only one instance in which expert medical input was sought for an inquiry into the death of an ADF member, and that was not in relation to a death by suicide.¹⁸⁸ We do not regard this as satisfactory.
259. In our view, assistance from a psychologist or other qualified mental health expert should be mandatory and obtained in respect of the critical matters referred to earlier in all inquiries into deaths of ADF members, save for where suicide can be categorically excluded as the cause of death. Such assistance from a subject matter expert would only enhance the process and investigation that is undertaken.
260. For example, Assurance Check Report 22-04 identified that of the 57 matters examined, 28 or 49% identified relationship breakdown as a relevant factor contributing to death.¹⁸⁹ However, as the ADFHQ SSIM staff member who conducted the analysis told us, in 12 of the reports ‘there was no detail as to why the relationship may have broken down’, and whether aspects of service life may have contributed.¹⁹⁰ Subject matter expertise from a psychologist or other qualified mental health expert may assist in assessing matters of this kind.
261. Qualified mental health experts may also be able to provide valuable assistance in analysing the member’s medical and psychological files provided by the DSCAE, particularly given that this information can be cumbersome and difficult to access.¹⁹¹
262. We accept that it may not be practicable to have a mental health expert such as a psychologist on the permanent staff of the DSIR to provide the assistance described. If so, the assistance should be obtained from an external provider using, for example section 110O(2) of the Defence Act.

12.3.7 Timeliness

263. The length of time taken for Inspector-General inquiries relating to deaths by suicide to be completed and reports produced is a major concern.

264. Assurance Check Report 22-04 considered 59 Inspector-General reports into deaths by suicide of 57 members dated between June 2016 and June 2022. It found that:

7. The average time between the date of death and release of the IGADF Report was 575 calendar days.

8. The average number of days between the member's death and release of the IGADF Report was higher for:

- a. the death of permanent members (610 calendar days)
- b. reports with recommendations (678 calendar days)
- c. reports that found there was a Service nexus (690 calendar days)
- d. reports involving allegations of unacceptable behaviour (786 calendar days).¹⁹²

265. Extended timeframes such as these are unsatisfactory for several reasons:

- Long delays can have adverse impacts on the family and friends of the deceased.¹⁹³
- Other ADF members who were involved in the circumstances contributing to the deceased member's death may be adversely affected.¹⁹⁴
- Recommendations designed to address systemic or other issues may not be known until more than two years after the death, making it difficult to effect systemic change in an organisation where there are often two-year posting cycles in units.¹⁹⁵
- Those in command of the deceased, who may be vitally interested in the report and implementation of actions arising out of it, will likely have been posted elsewhere by the time it is released, given the typical posting cycle of the ADF.

266. Witness MB2 described the significant impact of the length of time it took to conduct the inquiry into the suicide death of her late husband. He died in June 2021, and when she appeared at Hearing Block 11 in August 2023 – some 26 months after his death – the final inquiry report had not been completed.¹⁹⁶

267. She told us she was 'in a constant sort of limbo' waiting for the report.¹⁹⁷ She was invested in the outcome of the report and anxious about what it would say.¹⁹⁸ The delay was stopping her from moving forward.¹⁹⁹ MB2 said that the time taken to complete the inquiry process had 'really stretched out ... the grieving process'.²⁰⁰

268. Mr Gaynor accepted that time taken to complete inquiries can be a source of stress for the next of kin, family members, and others – including people implicated in an inquiry.²⁰¹ This was also the view of another witness from the DSIR, who accepted that long delays can have impacts on family members and friends of the deceased, and on the wellbeing and mental health of ADF members who may have been involved in some way in the circumstances contributing the death.²⁰²

269. The Deputy Director acknowledged that the average timeframes identified in Assurance Check Report 22-04 are too long, and that DSIR processes need to be directed at reducing these timeframes.²⁰³
270. Although Assurance Check Report 22-04 was concerned with reports produced during the period from June 2016 to June 2022, the evidence suggests that the lengthy timeframes for conducting inquiries and producing the associated reports continue.
271. The June 2023 Noting Brief from the Inspector-General to the CDF provided a status update on 26 open inquiries involving suspected suicide deaths.²⁰⁴ These included deaths by suspected suicide dating back two years or more.
272. There may be many reasons why it can take a long period to complete an inquiry and produce a report into the death by suicide of an ADF member.
273. There may be factors external to the Inspector-General. For example, it may take a long time to obtain required information. The next of kin and family members may need time before they are prepared to engage with the inquiry and provide information. There can be issues with witness availability. It can take time for the next of kin and family members to review draft reports. Procedural fairness processes may need to be accommodated. And unforeseen events, such as the COVID-19 pandemic, can disrupt travel and impose other restrictions.
274. It has also been suggested that the performance of the DSIR, at least in recent times, has been impacted by demands placed on the Office of the IGADF by the Office of the Special Investigator²⁰⁵ and by this Royal Commission.²⁰⁶
275. According to the Deputy Director, however, there are systemic issues in the Office of the IGADF that have contributed to the lengthy timeframes to complete inquiries and produce reports.
276. The first systemic issue concerns continuity of staffing. The Deputy Director said that from his perspective:

So continuity of staffing has been an issue both within my tenure but anecdotally, I understand, prior to my tenure. I appreciate that many workplaces have to shoulder staffing vacancies and a lack of continuity but I think when you have a directorate that is inquiring into the deaths of service members, our workplace is less able to sustain staffing issues for a protracted period of time. So that's the first systemic issue that I see being relevant to the directorate.²⁰⁷

277. The second systemic issue concerns the absence of key performance indicators (KPIs):

I do think it is necessary to establish performance targets and KPIs, not only to set them but to stick to them as well and to take appropriate remedial action when performance targets and KPIs are not met.²⁰⁸

278. The third systemic issue he noted is the lack of suitably qualified and trained Assistant Inspectors-General:

[O]nce again purely from my level as an observation ... the assistant IGs [Inspectors-General] who conduct our inquiries and who comprise our inquiry teams need to be managed as a capability – so they need to be recruited, retained, they need to be trained, and there needs to be continual training for them. And on that last point, there has at times been an issue with, from my perspective, the availability of reliable assistant IGs who can conduct these sorts of inquiries with the right skillset and who are available for the time that it takes to conduct these inquiries.²⁰⁹

279. Overall, the time taken to complete inquiries into the deaths of ADF members can be too long and needs to be reduced.

280. We have already discussed staffing of the Office of the IGADF. Staffing shortfalls in the DSIR need to be addressed by recruiting additional suitably qualified staff.

281. Further, the Inspector-General should consider changing the operating model that has historically been used in conducting inquiries into deaths of ADF members, so reservists appointed as Assistant Inspectors-General to conduct them are not as heavily relied upon.²¹⁰ Reservists' circumstances may reduce their ability to devote time to an inquiry. It has been put to us that having inquiries conducted solely by reservist Assistant Inspectors-General can lead to inquiries taking long periods of time due to reservists' limited availability and competing professional commitments.²¹¹

282. A change might involve, for example, increasing the involvement of permanent DSIR staff members who would work with a reservist Assistant Inspector-General.

283. We have been told since Hearing Block 11 that the DSIR operating models have changed and that full-time DSIR staff are being upskilled and assigned to each inquiry alongside a reservist Assistant Inspector-General, and that in some instances two full-time staff are assigned.²¹² We encourage this initiative.

284. As referred to in section 12.2.3, the Inspector-General should also seek to have more people who are not reservists appointed as Assistant Inspectors-General to conduct inquiries.

285. As for KPIs concerning timeliness of inquiry reports, there are none in the Guidance Manual.

286. According to the Deputy Director, the length of time it takes to complete an inquiry is not something the DSIR routinely tracks or uses as a performance metric.²¹³

287. Mr Gaynor gave evidence that while KPIs have been identified, they have struggled to identify *meaningful* KPIs, and that while the Office of the IGADF's most crucial KPI is timeliness, the time inquiries take to complete depends on the availability of witnesses, as well as the complexity involved, particularly in cases of suicide. Another factor identified by Mr Gaynor as affecting timeframes is the availability of suitably qualified staff to undertake inquiries.²¹⁴

288. Mr Gaynor said that attempts to develop complexity matrices to account for factors such as these had proved fruitless.²¹⁵ He said it was not possible to impose a KPI of timeliness because of the sheer breadth of complexity of the different types of inquiries the Office of the IGADF conducts.²¹⁶

289. Mr Gaynor said that for this reason, a new set of KPIs had been incorporated in the most recent strategic plan, the IGADF Strategic Plan 2023–2025.²¹⁷

290. In the foreword to the IGADF Strategic Plan 2023–2025, it is stated that the plan ‘will act as a guide and will be underpinned by supporting processes and procedures to ensure that we are trusted and promote fairness in the ADF and Defence Communities’.²¹⁸ The plan recognises that confidence in the Office of the IGADF’s technical competence can be increased by improving timeliness of report delivery, and includes as a goal ‘improve timeliness’, and as a ‘goal measure’.²¹⁹

[b]arring exceptional circumstances, Inquiry Reports into the death of ADF members will be completed within a median of eight months from the date Inquiry directions are signed.²²⁰

291. Mr Gaynor also said that the metric he uses for the Office of the IGADF’s performance and accountability is not concerned so much with timeliness, but rather with ensuring that reports are conducted fairly and according to law. He said, ‘unfortunately, sometimes that takes time’, and that he measures the Office’s performance against this metric by reference to whether findings are the subject of a successful challenge²²¹

292. The Deputy Director said the metric he uses is the number of open inquiries at any point in time.²²²

293. In our view, KPIs concerning the time taken for an inquiry to be completed and a report produced are an essential accountability mechanism. Those in the DSIR conducting inquiries should aim towards a fixed number of days or months by which their work should be completed.

294. KPIs should be worded so that the time metric begins on the date the death is notified to the Inspector-General, not the date on which written directions for an inquiry are made. Timeframes should be expressed in absolute terms, rather than by reference to average or median values.

295. We accept that the timeframes for an inquiry into the death of a member by suicide may be affected by procedural fairness processes, particularly where adverse findings or recommendations directed at a specified individual or agency are proposed. This should be allowed for in the formulation of timeline KPIs for the DSIR.

296. Performance against time-based KPIs and the average days taken to complete inquiries into the deaths of ADF members, including deaths by suicide, should be reported by the Inspector-General in Annual Reports.

12.3.8 Interactions with next of kin and families

297. Interactions with next of kin and families is a critical aspect of the death inquiry process. If not handled well, the anguish of next of kin and others may be exacerbated.
298. DSIR staff interact with next of kin and other family members at various stages during an inquiry into the death by suicide of an ADF member.
299. According to the Guidance Manual, there are at least four occasions when it is appropriate to contact the next of kin, namely:
1. to provide initial information regarding the IGADF's role and that an inquiry is proposed to occur;
 2. seeking to interview the next-of-kin as part of an IGADF inquiry ... ;
 3. when providing the draft report to the next-of-kin for review and input (usually through a legal officer allocated by Defence Counsel Services);
 4. to advise the family of the completion of the IGADF assessment or inquiry.²²³
300. The Guidance Manual appropriately recognises that all communications with next of kin must be made in a sensitive, respectful and in a trauma-informed manner.²²⁴

Initial advice letters

301. The Guidance Manual states that, as a general rule, initial advice letters should be sent to the next of kin four to six weeks after the death of a member.²²⁵
302. The letter informs the next of kin that the Inspector-General is reviewing the circumstances of the death and invites them to contribute to the review. The letter also sets out support services that are available.²²⁶
303. Initial advice letters may also be sent to other family members in cases where the dynamics of family relationships make this necessary.²²⁷ The decision as to whether this is necessary is based on information obtained from the Defence Member and Family Support Branch.
304. The Deputy Director told us that initial contact with a family through these letters is, on average, six weeks after the date of death.²²⁸
305. It was put to us following Hearing Block 11 that it would be more accurate to say that initial advice letters are generally sent within four to six weeks of the DSIR being notified of a death, and that the Office of the IGADF is not always immediately notified of deaths when they occur. This is particularly the case for service category 2 inactive reserve members who are not posted to units.²²⁹

306. Whatever the situation is, we have been told of instances where no contact was made by the Inspector-General with the next of kin until 10 months and more than three years after the death.²³⁰ The Deputy Director accepted that these represent clear lapses in DSIR processes and said they are not up to the standards expected.²³¹
307. Such lengthy periods should not occur and are not consistent with trauma-informed practice.
308. In our view, initial advice letters should be sent by the Inspector-General to the next of kin within four weeks of the date on which the Inspector-General is notified of the death.

Interviewing next of kin

309. The second engagement with the next of kin is when the DSIR conducts interviews as part of the Inquiry and Report Writing Phase that is now applied where suicide is suspected. This is after written directions for the more formal inquiry have been issued.²³²
310. The Deputy Director told us that the interview is ‘a comprehensive trauma-informed interview’, and that a primary role of the interview is to get the next of kin’s perspective on any service-related issues. He further said that the directions for the inquiry make it clear that the interview is to focus on matters such as suicide risk factors, and any acts or omissions by the ADF or Defence that may have contributed to the death.²³³ He said there are no scripts that guide how interviews are conducted.²³⁴
311. Interviews can be particularly stressful and challenging for the next of kin and family members. Conducting them in a trauma-informed way is essential.
312. This is recognised by the Guidance Manual, which states that communication with the next of kin in a sensitive, respectful and trauma-informed manner is paramount, and that:
- [t]he importance of addressing family matters in a compassionate, sensitive and trauma-informed manner cannot be overstated. The involvement of the next-of-kin and family members is fundamental to DSIR processes.²³⁵
313. Two issues are of concern to us.
314. The first concerns the training that is provided to DSIR staff to ensure they have the skills to conduct interviews with next of kin in a trauma-informed way.
315. Interviews can have significant impacts on next of kin, and may exacerbate the trauma experienced as a result of the death.
316. The Deputy Director said that inquiry teams are selected on their ability to engage with the next of kin in a sensitive manner.²³⁶ However, the way in which this assessment is made was not explained.

317. In our view, it is essential that all staff members of the DSIR who engage with next of kin for the purposes of an inquiry into the death of an ADF member, including by conducting interviews, are trained in trauma-informed practices. This includes consultants, who we were told conduct interviews as Assistant Inspectors-General.²³⁷
318. There is no requirement for such training in the Guidance Manual.
319. The Deputy Director told us that all full-time members of the DSIR have completed the Compassionate Foundations course, and said that the Inspector-General had made the course mandatory for all full-time members of the Office of the IGADF.²³⁸
320. The Compassionate Foundations course is an online learning program comprising six modules, delivered through the Department of Defence's online training platform. It is 'designed to support positive human-to-human interactions that promote connection and understanding'.²³⁹
321. The Deputy Director was unclear, however, on the extent to which reservists in the staff of the DSIR and consultants had completed the course.²⁴⁰ He agreed that this training should be mandatory for all DSIR staff, including reservists and consultants, not only those who are full time.²⁴¹
322. Information we received suggests that around 54% of staff in the DSIR had completed the Compassionate Foundations course or other similar training.²⁴²
323. We believe that it is essential that all staff members of the DSIR and consultants who engage with the next of kin for the purposes of an inquiry into the death of an ADF member have completed the Compassionate Foundations course or equivalent training before they do so. Refresher training should also be completed by DSIR staff members every two years.
324. The need for this training applies similarly to those in the DSIR who conduct interviews with witnesses for the purposes of an inquiry, given that witnesses may also be significantly impacted by the death of a member.
325. We have been told that since Hearing Block 11, the Guidance Manual has been updated so that the Compassionate Foundations course must be completed by DSIR staff before they engage in DSIR matters.²⁴³ This is a positive.
326. We also heard evidence suggesting that there was no quality-assurance process in place to ensure that interviews and other engagements by the DSIR with next of kin are conducted in a trauma-informed way.²⁴⁴ It may be, however, that this will be a function of a new post-inquiry cell being established in the Office of the IGADF, which we discuss in section 12.6.6. Quality assurance should be introduced, including through obtaining regular post-inquiry feedback.
327. The second issue of concern is in relation to the appointment of a legal officer from Defence Counsel Services (DCS) for the purposes of an inquiry. DCS is a Defence directorate that provides legal assistance to current and former ADF members.²⁴⁵

328. According to the Guidance Manual, ‘the role of DCS-appointed legal officers, in cases involving death by suicide, has evolved and acquired increased importance’.²⁴⁶
329. The Deputy Director told us that in cases of suspected suicide, a DCS legal officer is now appointed when written directions for an inquiry are issued. He further said it is usually the DCS legal officer who initiates the personal communication with next of kin or family and gives them notice that the Inspector-General would like to speak with them.²⁴⁷ He also told us that the DCS legal officer attends the interview with the next of kin in person, although sometimes the legal officer may do so by phone.²⁴⁸
330. It has not, however, always been the case that a DCS legal officer is appointed, or that the next of kin or family members are contacted by a DCS legal officer, including before an interview is conducted with them.²⁴⁹
331. For example, witness MB2 told us that despite being informed ‘early on’ in an email from the Office of the IGADF that a DCS legal officer had been allocated to her husband’s case, she had never had any contact from that legal officer. This is despite the fact that her husband had died by suicide in mid-2021, she had been interviewed (by phone) in May 2022 and she had provided further information to the Office of the IGADF in response to requests. (At the time of Hearing Block 11 in August 2023, she was still waiting for the Inspector-General’s report.²⁵⁰)
332. This should not be allowed to occur, especially in situations where the next of kin or family members do not have their own legal representation.
333. We understand that DSIR practices have now changed. The Guidance Manual is being updated to provide that the DSIR write to DCS requesting that a DCS legal officer be appointed, inquiry teams are not to contact the next of kin until the DCS lawyer is appointed, and the DCS legal officer is to be invited to the initial engagement with the next of kin.²⁵¹
334. We trust these practices will be followed.
335. That said, it is important to recognise that a DCS legal officer is appointed to represent the interests of the deceased ADF member and does not act for the next of kin or other family members.²⁵² Insofar as the next of kin and other family members are concerned, the appointed DCS legal officer is only a source of information for them and a means by which they can communicate with the relevant Assistant Inspector-General in connection with the inquiry.²⁵³
336. Nevertheless, as the Deputy Director put it, the ‘DCS legal officer is an important conduit with the next of kin’.²⁵⁴ The fact that a DCS legal officer is appointed and performs this limited function should relieve some of the pressure and anxiety that next of kin and family members may experience about interviews with the Inspector-General, and about the Inspector-General’s processes generally.

Updating next of kin during an inquiry

337. While the Guidance Manual says that there are *at least* four occasions when it is appropriate to contact next of kin and family, as referred to earlier in this section, it makes no comment about other contact, for example to update them on the status and progress of an inquiry.
338. Witness MB2 told us that after being interviewed in May 2022 in relation to her partner's death by suicide in mid-2021, she received only sporadic contact from the Inspector-General. She said that months would go by without her hearing anything. She said that due to this silence, she and her husband's family had been obliged to reach out to try and get an update.²⁵⁵ She said she felt that she had to carry the burden of initiating communication.²⁵⁶
339. Another witness told us that after being interviewed, he heard nothing for over 12 months.²⁵⁷
340. There was also a witness who told us that her communications with the Inspector-General were ad hoc and that the onus was consistently on her to chase up the Office of the IGADF for updates on progress.²⁵⁸ Another said that updates were provided intermittently and about every couple of months, often after the Inspector-General was contacted.²⁵⁹
341. Witnesses at our Brisbane hearings told us that after being shown the draft report into the death by suicide of their son two years previously, they heard nothing more from the Inspector-General.²⁶⁰
342. Mr Gaynor told us that 'the general rule in the office is that people connected with an inquiry are contacted on a monthly basis'; however, he conceded that this 'has not always happened'.²⁶¹
343. Mr Gaynor also conceded that this 'general rule' does not appear in the Guidance Manual,²⁶² and nor is it recorded anywhere else.
344. The Deputy Director accepted that what had happened with witness MB2 was not up to the standard expected in the DSIR and that 'there has been a delay in that matter which we are working hard to address'.²⁶³ He said that inquiry teams exercise a large degree of discretion, including in relation to the regularity of communications with next of kin and family members. He said:
- we could be more structured in the way or the requirements for engagement ... and keeping ... the family and the next of kin up to date with the progress of the inquiry.²⁶⁴
345. We agree. Periods of silence and a lack of clarity on when to expect communication can be a source of great stress. Family members and next of kin can also feel burdened by having to chase information.²⁶⁵

346. Regular updating should also be provided to witnesses who are interviewed for an inquiry into the death of an ADF member. Silence as to the status of an inquiry can be stressful for witnesses as well, particularly where their conduct has been called into question.²⁶⁶
347. Unless next of kin or witnesses have clearly told the Inspector-General they do not want regular updates on the progress of an inquiry, they should be regularly updated.
348. Updates should be provided by direct communications from the DSIR in accordance with the preferences of those who are receiving them, and when they occur should be predictable. In our view, updates should be monthly, unless those receiving the updates request otherwise.
349. In terms of how updates are provided, unless the next of kin or others require updates to be provided differently, the Inspector-General should establish a portal that is accessible by next of kin, family members and witnesses, and on which updated information about the current status of the relevant inquiry is given.
350. The information communicated through the portal might reflect the categories the Inspector-General has used when updating the CDF on the status of inquiries:
- Inquiry being scoped, Inquiry in progress, Inquiry team drafting Report , Draft Report ready for/with [next of kin]/family, Draft Report undergoing review following [next of kin]/family consultation, and Draft Report final stages for IGADF signature.²⁶⁷
351. Using categories like these on a portal that is updated monthly would be a convenient way of keeping the next of kin and others informed of inquiry progress.

Providing inquiry reports to next of kin

352. Once a draft of an inquiry report has been prepared, it is typically made available to the next of kin for review and input. This engagement is usually facilitated by the DCS legal officer unless the next of kin has retained legal representation privately.²⁶⁸
353. The next of kin may provide input to the DSIR staff member who is present at the meeting where the draft report is shown to them. They are also invited to make any further written submissions through the DCS legal officer, if the legal officer has been appointed and is present. The DCS legal officer is also invited to make a submission on the draft report.²⁶⁹
354. At the conclusion of an inquiry, next of kin and families may be given an opportunity to read an unredacted copy of the final report. As explained by the Deputy Director:
- we also try to allow them to, for example, if we conduct a supervised reading which will allow the family and the next of kin to read an unredacted copy of the report, we will also make the offer that if they want to read it again or if there were other – for example, if there were children, when they became of age and wanted to read the report, we would offer them to be able to do that at a later date.²⁷⁰

355. The Guidance Manual further provides that where death by suicide is involved, next of kin will be provided with a copy of the final inquiry report, redacted for privacy.²⁷¹
356. Commonly, when next of kin are given access to a draft inquiry report, an unredacted final report or a redacted final report, they are subject to non-disclosure directions pursuant to section 21 of the IGADF Regulation.²⁷²
357. In relation to the draft report, the Guidance Manual states that:
- the IGADF ... will issue directions to the next of kin and the [DCS] legal officer (or lawyer acting for the next-of-kin) restricting disclosure under section 21 of the [IGADF Regulation].²⁷³
358. A 'direction' under section 21 of the IGADF Regulation prohibits disclosure of information beyond specified exempted persons. Contravention of a section 21 direction is an offence.
359. We have concerns about these directions.
360. Section 21 of the IGADF Regulation provides that the Inspector-General (or an authorised Assistant Inspector-General) may give a direction restricting the disclosure of specified matters where they are satisfied that it is necessary to do so in the interests of the defence of the Commonwealth, or in fairness to a person who may be affected by an inquiry. The specified matters are:
- information contained in oral evidence given during the inquiry, whether in public or in private
 - all or part of any document received during the course of the inquiry
 - information contained in a report about the inquiry that is given to a person under section 27.²⁷⁴
361. Section 27 of the IGADF Regulation obliges the Inspector-General to give the CDF a report of an inquiry into the death of an ADF member. It also gives the Inspector-General discretion to give the report to other people, including next of kin. Where the Inspector-General gives the report to another person, the Inspector-General may, under section 27(7), exclude any information that they consider would be inappropriate to disclose. This may be for privacy reasons, or because the information is classified or relates to national security.²⁷⁵
362. The Guidance Manual is silent as to the terms of non-disclosure directions that are made.
363. In practice, non-disclosure directions under section 21 of the IGADF Regulation are expressed so as to cover *all* of the information contained in a draft or final report (redacted or unredacted) concerning the death of an ADF member, not just information that might be regarded by Defence as operationally sensitive.²⁷⁶ This is the case even though (according to the Deputy Director) the directions are 'really directed at ensuring that the identity of witnesses, findings, recommendations and content of a report are kept confidential'.²⁷⁷

364. Non-disclosure directions can and often do contain ‘carve-outs’ or exceptions to allow disclosure to specific categories of people.²⁷⁸ These may be legal representatives, counsellors and specified family members.
365. The Deputy Director told us that the reason for making directions that cover all of the information in a report – even a report that has already been redacted by the Inspector-General under section 27(7) – is that ‘it is necessary to preserve the confidentiality and privacy of people mentioned in a report who are entitled to privacy rights’. He also said that reports need to be kept confidential if the Inspector-General is to exercise their functions properly.²⁷⁹
366. Mr Gaynor offered three reasons for such broad non-disclosure directions:
- The nature of an IGADF inquiry is that ‘we encourage witnesses to come forward and provide confidential information to us and we assure them that their information will, to the extent we can do so, be ... kept confidential’; non-disclosure directions are issued in respect of a redacted copy of a report because the report ‘will still contain information provided to us by other witnesses in confidence’.
 - Such directions are a way of maintaining confidentiality of information where, ‘in this internet age, it is far easier to publish copies of reports’.
 - Non-disclosure directions may protect against harm that might be caused by disclosure of a person’s involvement in an inquiry.²⁸⁰
367. We have heard from some families that non-disclosure directions can feel incredibly constraining.
368. The Deputy Director accepted that the framework around section 21 ‘could be potentially confronting and be causing additional distress for the next of kin, which of course we don’t want’. He noted he had not been aware of the issue until a family had recently questioned the non-disclosure directions and had raised an issue with them.²⁸¹
369. The fact that non-disclosure directions are expressed to cover all the information in a report might be understood by the next of kin as restricting them from discussing matters that are not confidential – for example, discussing information that they provided to the inquiry and that has been included in the report. As the Deputy Director acknowledged, this might impose an additional layer of distress for families.²⁸²
370. The Deputy Director also accepted that non-disclosure directions covering all of the information in a inquiry report could be perceived as Defence protecting itself because families are not able to talk about what was found, and where there may have been failings.²⁸³ As one witness put it, non-disclosure directions mean that there is a lack of transparency, which in turn means that there is a lack of accountability.²⁸⁴ A witness from the DSIR accepted that some people might see non-disclosure directions as ‘the organisation protecting itself’.²⁸⁵

371. We accept that there is a proper and important role to be played and a purpose that is served by appropriate non-disclosure directions, particularly in relation to draft reports. This is especially so because such directions can enable and allow next of kin to provide input on the draft that might be highly valuable for the inquiry, and that may mean that the final report differs from the draft report.
372. We also accept that witnesses may be encouraged to contribute to an inquiry where they are told that their confidentiality will be respected as far as practicable,²⁸⁶ and that non-disclosure directions may on occasion be made to protect the reputation of the deceased or their family.²⁸⁷
373. However, the right balance must be struck between protecting the interests of the defence of the Commonwealth and confidentiality and privacy rights on the one hand, and on the other, the interests of next of kin and family members. The interests of next of kin may include being able to discuss the report with people other than those specifically included in carve-outs to the directions, thus realising the full benefit of the report. After all, the report may be the only record next of kin and family members have about what happened to their loved one and why they may have taken their life.
374. In our view, there should be reforms in the making of non-disclosure directions regarding reports about deaths of ADF members.
375. First, it is not clear to us based on the evidence we have heard that it is always fully explained to the next of kin and family members that if they see an inquiry report (in draft or final form, redacted or unredacted), non-disclosure directions will be made, and what these directions mean.
376. Mr Gaynor pointed to the fact that the directions accompany a draft report, and said the appointed DCS legal officer consults with the families about what the directions mean.²⁸⁸
377. However, as we have already pointed out, the DCS legal officer represents the interests of the deceased, and does not act for the next of kin. The legal officer is a conduit for information, but that is different from having a responsibility to advise or to do what we believe should be done by the Inspector-General.
378. In our view, explaining the consequences and effect of the non-disclosure directions with the next of kin is not a shared responsibility with the DCS legal officer. It should be the responsibility of the Inspector-General and DSIR staff. This should be done by them directly rather than (for example) by giving next-of-kin a 'frequently asked questions' type of document.²⁸⁹
379. Second, in relation to the carve-outs that might be included in non-disclosure directions, Mr Gaynor's evidence was that these have to be specifically requested by the next of kin via the DCS legal officer. He said that 'what usually happens ... is that my staff will talk to the lawyer and find out who should be included in a section 21 direction so that ... the report can be shared with those people'.²⁹⁰

380. We believe the next of kin should be consulted directly by DSIR staff about which people should be specified in the carve-outs to a non-disclosure direction. Specified people should be included unless there is a good reason not to do so, particularly where they are other family members.
381. Third, it should be made clear to next of kin and family members that section 21 directions do not apply to information that they have provided to the inquiry or that they may know independently of anything contained in the draft or unredacted or redacted final report, and the directions themselves should expressly state that they do not apply to such information.
382. Fourth, the Inspector-General or authorised officer should avoid making non-disclosure directions that otherwise cover all of the information in an unredacted or redacted final report, unless it is absolutely necessary to do so.
383. Under section 21 of the IGADF Regulation, non-disclosure directions can be given that restrict the disclosure of matters referred to in (a) to (c) of the section, where the Inspector-General is satisfied that it is necessary to do so in the interests of:
- the defence of the Commonwealth
 - fairness to a person that may be affected by an inquiry.
384. In our view, restrictions on disclosure for redacted and unredacted final reports should only extend to those parts of a report that need to have disclosure restricted for these specific purposes, and not to *other* information contained in the report.
385. In relation to redacted copies of final reports, this may mean that section 21 directions need not be made, given that redactions will already have been made under subsection 27(7) of the IGADF Regulation.
386. Fifth, Mr Gaynor acknowledged that there was little by way of standard operating procedures in relation to the making and terms of non-disclosure directions, and about engagement with next of kin regarding directions.²⁹¹ He said that he relies on his inquiry directors to ensure directions are made at the conclusion of an inquiry 'in an informed way'.²⁹²
387. There should be comprehensive guidance for DSIR staff regarding the making and terms of section 21 directions. This comprehensive guidance should be in the DISR Guidance Manual and published on the Inspector-General's website so as to be accessible by next of kin and family members.
388. Sixth, we were told that there is no register of non-disclosure directions made under section 21 that is maintained by the Office of the IGADF.²⁹³ In our view, there should be.
389. Finally, in the interests of fairness, we consider that any person affected by non-disclosure directions should have the right to have the making or terms of the directions reviewed. This could be through a lawyer in the Directorate of Legal Review in the Office of the IGADF who has not otherwise been involved in that inquiry.

390. We also note that since Hearing Block 11, we have been told that at least some of the reforms outlined earlier in this section in relation to section 21 non-disclosure directions that are made in relation to reports concerning the deaths of ADF members have been, or are in the course of being, implemented.²⁹⁴ This is pleasing.

Debriefing next of kin at the conclusion of an inquiry into a death by suicide

391. Mr Gaynor told us that he had directed that debriefing of families is always to occur in relation to inquiries concerning deaths by suicide. He acknowledged that he did not make this direction in writing, but said it was ‘well understood’ in his office and was something that ‘we have done since at least January 2020’.²⁹⁵ Unfortunately, it appears that this has not always been happening.

392. In the Noting Brief for CDF: IGADF July 2023 Update, the Inspector-General told the CDF under item 6 ‘Family debriefs of IGADF suicide inquiries’:

Late last week I became aware that the IGADF DSIR had not been routinely advising [the families of those who died by suicide] of IGADF Inquiry outcomes. We are scoping the extent. The Acting DSIR’s explanation was that families were engaged during the Inquiry process and had read draft reports. I have implemented the interim arrangements described below to remediate this.²⁹⁶

393. These ‘interim arrangements’ are described as follows under item 7, ‘OIGADF interim arrangements’:

I have issued a Directive establishing an IGADF taskforce, led by Deputy IGADF, to identify, write to and offer to meet with [the families of those who died by suicide] who have never been advised of IGADF Inquiry outcomes. Deputy IGADF’s other duties will be shared with the Acting Assistant Secretary OIGADF and certain Directors.²⁹⁷

394. The fact that the next of kin and family members of ADF members who had died by suicide were not being routinely advised of the outcomes of the inquiry into their loved one’s death is plainly a matter of great concern.

395. This means, for example, that the next of kin and family members might not even have been advised that the inquiry into their loved one had been *completed* by the Inspector-General, where they may have been anxiously awaiting such notification.

396. In an example we have seen, a family were only advised that the inquiry into the death of their son by suicide had been finalised, and that the Inspector-General’s report had been provided to the CDF, five months after that occurred.²⁹⁸

397. Mr Gaynor said he first became aware of this issue during a regular monthly meeting with the Deputy Director of the DSIR.²⁹⁹ Asked whether this failing gave him cause for concern from a quality assurance perspective, Mr Gaynor said he was ‘absolutely appalled’.³⁰⁰ He said it did cause him to be concerned about quality assurance within the DSIR, and that he relies on his senior staff for quality assurance.³⁰¹
398. Mr Gaynor put the failing down to the DSIR having had a high staff turnover, and having been without a director ‘for some time’.³⁰²
399. For his part, the Deputy Director said the issue ‘was something that we have been aware of certainly throughout my tenure’, and that it was ‘related to capacity issues’. He further told us that he and the previous Director had started scoping the issue in late 2022 in an attempt to remedy it as soon as they could. He said ‘unfortunately [we] haven’t done a good job in that area and we have to fix it’.³⁰³
400. As to the precise failure with processes, the Guidance Manual provides that where there is a report concerning a death by suicide, a copy of the report, redacted for privacy, is to be provided to the next of kin ‘on request’ at the same time that it is provided to the CDF, and that in appropriate cases the Inspector-General may direct, or the CDF may request, that the family is to be approached again to be provided with a debriefing on the final report.³⁰⁴
401. Mr Gaynor, however, said he had directed that a debrief was *always* to occur at the conclusion of inquiries into deaths by suicide. He said that while this direction was not in writing, it was ‘well understood’ in his office and was something ‘we have done since at least January 2020’.³⁰⁵
402. It is of concern to us that a direction as important as this would not be in writing and clearly reflected in guidance, as opposed to being left to people’s ‘understanding’ in a directorate with a high staff turnover. This needs to be remedied.
403. We acknowledge that upon becoming aware of the issue, the Inspector-General took action to fix it.
404. That action was to issue *IGADF Directive 02/2023*,³⁰⁶ which appointed the Deputy Inspector-General to lead a taskforce to review the work of the DSIR and, among other things, to:
- [identify] which families had not been advised of inquiry outcomes and then to arrange for those families to be contacted in a trauma-informed way and to arrange for them, if they wished, to read an unredacted copy of the report and to be provided a privacy-redacted copy of the report if they wanted one.³⁰⁷
405. Another aim of the taskforce was stated as being to ‘develop a model for the future’.³⁰⁸ Plainly, any such model for the future should ensure that there is no repeat of the lapses the led to families not being informed about inquiry outcomes.
406. Since Hearing Block 11, we have been informed that all families have been advised of inquiry outcomes.³⁰⁹

12.3.9 Deaths by suicide of former ADF members

407. The Inspector-General's function under section 5(a) of the IGADF Regulation is to inquire into the deaths of ADF members. It does not extend to inquiring into the deaths of former members of the ADF, whether the death is by suicide or another cause.
408. We heard evidence of one occasion where the Inspector-General did inquire into the death by suicide of an ex-serving ADF member. That was in circumstances where the suicide occurred 'a matter of weeks or potentially months' after the member separated from service,³¹⁰ and the Inspector-General was concerned that aspects of the member's service might have contributed to the death.³¹¹ The Inspector-General sought a direction from the CDF to inquire into the death under section 110C(1)(f).
409. There is merit in expanding the jurisdiction of the Inspector-General given that service may well be contributing factor to a death by suicide that occurs after separation.
410. Further, as explained in the data annexure in Chapter 1, Understanding suicide, and in Chapter 10, The ADF military justice system, ex-serving members who separate involuntarily are at increased risk of suicide and suicidality.
411. Mr Gaynor said he was not opposed to an expanded jurisdiction.³¹² As to the risks and benefits, he said:

Well, the risks are resourcing risks, I suppose. You know, I would need more resources for an expansion in that way ... I believe, though, that there would be advantages in extending the jurisdiction with respect to suicides beyond service tenure ...

... I don't see any practical difficulties. My office, essentially, has the powers of a Royal Commission when it comes to death inquiries. Not all of the same features apply, but we can compel evidence from any person.

412. In our view, a period of two years from the date of separation would be an appropriate and valuable extension of the Inspector-General's jurisdiction.
413. It is to be expected that there might be practical difficulties in the Inspector-General inquiring into a death by suicide of a former member that occurs long after separation.³¹³
414. For this reason, and being mindful of the practical implications for the Inspector-General in terms of increased workload, we consider that the expanded jurisdiction of the Inspector-General should apply to deaths of ex-serving members by suicide that occur from 30 September 2024, and within two years of separation.

415. Another practical issue with an expanded jurisdiction concerns reservists. Under section 22 of the Defence Regulation, there is the '5-year rule', which provides that service as a reservist ends if the member has not been required to render service for a continuous period of five years. Where separation has been for this reason, the links to service may be diminished, as might knowledge about the member. Presumably this is already a challenge for inquiries under the existing jurisdiction, including as to the Inspector-General's ability to learn of a death by suicide and inquire into it. However, we do not see that extending the Inspector-General's jurisdiction by an additional two years after separation materially changes the situation in this respect.
416. We also acknowledge that use of the expanded jurisdiction will be dependent upon the Inspector-General learning of the death of a former member. Defence and other Government agencies (including DVA) should be required to inform the Inspector-General whenever they become aware that a former ADF member has died by possible suicide.

12.3.10 Coroners

417. The Inspector-General's function in relation to inquiring into the deaths of ADF members can overlap with the work of coroners.
418. As we have noted, obtaining coronial documentation is an essential part of the information gathering (preliminary) phase of an inquiry by the Inspector-General.³¹⁴
419. In some jurisdictions, notices are issued to coroners to provide this material under section 23 of the IGADF Regulation, while in other jurisdictions this is not necessary.³¹⁵
420. The DSIR conducts inquiries concurrently with the work of the relevant coroner and does not wait for the coroner's report or for the conclusion of a coronial investigation.³¹⁶
421. Surprisingly, there are no formal arrangements between the Inspector-General and coroners across various jurisdictions. It was put to us by the Inspector-General that a formal arrangement, such as a memorandum of understanding, might reduce the independence of each office.³¹⁷
422. We have not heard evidence that the lack of a formal arrangement is creating material issues for the Inspector-General's inquiries, or is an issue from the perspective of timeliness.
423. However, the lack of coordination between the Inspector-General and coroners may have consequences for the next of kin and family members of a deceased member. Being interviewed in relation to the death of a loved one can be confronting and harrowing. To have to be interviewed by separate agencies for separate processes compounds the challenges.

424. When asked whether there was any collaboration between the Office of the IGADF and coroners to minimise the stress on the next of kin associated with having to give multiple interviews, the Deputy Director said:³¹⁸

I think at the moment that's not something that our processes have matured enough to address ... there's certainly communication with the coroners to request their documentation, but there's not [been] liaison from the perspective of ascertaining whether they have already been interviewed and things like that.

425. We would encourage the Inspector-General to explore with coroners what might be done to avoid unnecessary duplication, notwithstanding the constraints related to the two separate processes.
426. The role of coroners in investigating deaths by serving and ex-serving members is discussed more fully in Chapter 28, Coroners.

12.3.11 Trend analysis

427. The Inspector-General obtains an enormous amount of information in relation to deaths by suicide through the function of inquiring into deaths of ADF members.
428. It is surprising, then, that no longitudinal or trend analysis of inquiry reports into deaths by suicide is conducted as a matter of practice by the Inspector-General, for example to identify common themes and risks, and systemic factors.³¹⁹ Such an analysis would likely be extremely valuable to Defence.
429. Mr Gaynor said that work of this kind had only been done once within his office. This was at the start of 2020 in connection with data provided to the Australian Institute of Health and Welfare, which fed into work of the interim National Commissioner for Defence and Veteran Suicide Prevention. He noted that reference had been made to this analysis in the Inspector-General's most recent Annual Report.³²⁰
430. Otherwise Mr Gaynor said that any longitudinal analyses of the Inspector-General's reports is a matter for the select incident management cell in ADFHQ. Mr Gaynor said that while he personally monitors themes of causative factors in the reports by signing off on them, he relies on ADFHQ to undertake any analysis of them.³²¹
431. As referred to in section 12.3, in 2022 SSIM in ADFHQ produced Assurance Check Report 22-04, which provided a non-technical analysis of 59 Inspector-General reports dated between June 2016 and June 2022 regarding the deaths by suicide of 57 ADF members.
432. As detailed in Assurance Check Report 22-04, a number of common factors to the suicides were identified in this analysis, including mental health issues (61%); relationship breakdowns (49%); mental health issues and relationship breakdowns (32%); chronic pain, injury or illness (19%); alcohol (18%); and concerns about the member's ADF career (16%).³²²

433. To assist the CDF in preparing for our Sydney hearings in March 2024, ADFHQ conducted a further non-technical review of 80 Inspector-General reports concerning personnel suspected or confirmed to have died by suicide since 1 January 2013 to identify prevalent factors identified in the reports. The findings of this review were similar to the findings concerning common factors detailed in Assurance Check Report 22-04.³²³
434. The interim National Commissioner for Defence and Veteran Suicide Prevention, Dr Bernadette Boss CSC, told us about the advantages of this kind of analysis.³²⁴
435. As to whether the Inspector-General should regularly conduct a trend analysis of inquiry reports concerning deaths by suicide, Mr Gaynor said he was open to the suggestion although he would not want to duplicate work that might otherwise be done by Defence.³²⁵
436. We do not think that whatever work might be being done in ADFHQ or otherwise in Defence is a reason for the Inspector-General not to undertake periodic analysis of reports concerning suicides to ascertain trends, common themes and factors. That this is not happening as a matter of course represents a lost opportunity, and suggests a lack of curiosity. This kind of analysis can only benefit Defence, and should be done by the Inspector-General.
437. Such analyses by the Inspector-General should also review the findings and recommendations made in reports, to determine whether there are common matters being addressed by recommendations in different reports, or indeed whether similar recommendations keep being made. This would assist in identifying systemic issues.
438. We have already recommended that the Inspector-General obtain the assistance of a qualified mental health expert such as a psychologist in respect of its inquiries into deaths by suicide. This subject matter expertise should also be obtained in connection with trend analyses conducted by the Inspector-General.
439. So as to facilitate trend analyses of this kind, the Inspector-General should ensure that common data sets are included in Inspector-General reports regarding deaths of ADF members by suicide or suspected suicide. This was a gap identified in Assurance Check Report 22-04. These common data sets referred to in Assurance Check Report 22-04 included SERCAT category, relationship status, military justice history, sub-unit details, location and civilian occupation.³²⁶

12.3.12 Implementing the Inspector-General's recommendations

440. Reports of inquiries into deaths of ADF members can contain significant recommendations.
441. For example, the Deputy Director agreed that a May 2022 report essentially said that annual suicide awareness training is not having a suitable impact, particularly for junior members.³²⁷ The Deputy Director further agreed that the report included a recommendation in order to make suicide awareness training more meaningful to junior personnel.
442. While the implementation of recommendations made in Inspector-General reports that are accepted by the CDF (as made or in modified form) is a responsibility of ADFHQ, there does not appear to be any formalised process of reporting back to the Inspector-General about the implementation of recommendations in particular reports.
443. The Deputy Director told us that he was not aware of any further engagement once a report goes to ADFHQ.³²⁸
444. Witnesses from ADFHQ also told us there is little further engagement with the Inspector-General or Office of the IGADF staff after ADFHQ receives a report. They also said communication tends to be limited to seeking clarification on recommendations that are ambiguous or unclear.³²⁹ On rare occasions, ADFHQ refers a matter back to the Inspector-General if it receives representations from persons affected by an inquiry that the inquiry missed elements of their evidence or complaint.³³⁰
445. Mr Gaynor put things differently. He said:
- only very few recommendations ... from inquiry reports that we have [made] have not been following up ... most if or not all recommendations that are communicated to Defence Force Headquarters arising out of that directorate's inquiries are also the subject of ... formal implementation plans. So, it's ... only a very small number of the recommendations that my office makes ... which are not followed up.³³¹
446. Whatever the position, and in addition to the more general dialogue that appears to occur regularly between ADFHQ and Office of the IGADF staff,³³² ADFHQ should, as a matter of course, routinely and formally advise the Inspector-General and the Director of the DSIR about the extent to which:
- recommendations have been implemented
 - recommendations have not been implemented, and the reasons why.
447. This information will likely assist the Inspector-General in discharging the function of inquiring into the deaths of ADF members by suicide, and consideration of the recommendations that might be made.

12.3.13 General observations in relation to the DSIR

448. Mr Gaynor described the DSIR as a directorate that is ‘under stress’.³³³ This was certainly our impression.
449. At the time of Hearing Block 11, there had been two Directors in the previous two years and the position was vacant with the Deputy Director fulfilling the role in an Acting Director capacity.³³⁴ There had been high staff turnover, capacity and quality issues had been identified, and there were challenges finding appropriately qualified and experienced staff.
450. We further heard about lapses that had occurred in contacting next of kin, and in debriefing next of kin and families following the conclusion of inquiries.
451. The Inspector-General had concerns about quality assurance in the DSIR, and had directed the Deputy Inspector-General to review the DSIR with one objective being the development of a future-focused operating model. The Inspector-General was also changing the approach to leadership of the DSIR.
452. Practices in the directorate were not all fully recorded as formal guidance, with some left to unwritten ‘understandings’. There were further gaps in the training that DSIR staff might be expected to have completed, and recommendations in reports were not being formally followed up.
453. We have been told that since Hearing Block 11, there have been a number of changes and actions taken in relation to the DSIR.³³⁵
454. These include:
- a restructure of the directorate with more APS staff to be employed as Assistant Inspectors-General when they have been sufficiently trained
 - the appointment of a new civilian director, who ‘has significant experience in investigating deaths and in managing investigations/inquiries’ and has ‘experience of undertaking investigations requiring sensitive management’
 - the creation and filling of two additional permanent APS positions
 - the creation of a new EL1 coordination role with responsibility for ensuring compliance and improving governance
 - changing the DSIR’s operating model, with a greater reliance on full-time staff and less reliance on reservists
 - full-time staff (and sometimes two) being being upskilled and assigned to each inquiry alongside experienced reservists and sometimes consultants

- a more trauma-informed approach being used whereby next of kin are contacted early in an inquiry and told upfront about timeframes for information gathering, and staff needing to complete the Compassionate Foundations course before engagement in DSIR matters
 - changes in relation to the making and terms of section 21 non-disclosure directions
 - changes to procedures in relation to engagement with next of kin and the appointment of a DCS legal officer
 - a full review and update of the Guidance Manual by the new Director.³³⁶
455. We have also been told that further APS staff will be employed once recent appointees have been sufficiently trained.³³⁷
456. These changes are encouraging, and it is to be hoped that they will go some way to addressing the issues that have been identified with the discharge of the Inspector-General's vital function of inquiring into the deaths of ADF members, including those suspected to have died by suicide.

12.4 The DMRR: considering ROG complaints

457. The DMRR is the Office of the IGADF directorate that assists the Inspector-General in discharging the Inspector-General's function in relation to redress of grievance complaints.

12.4.1 Overview

458. ROG is a formal complaint process by which ADF members may complain to their chain of command about a decision, act or omission relating to their service.
459. ROG is a long-standing right of military members to have wrongs or unfairness addressed.³³⁸ As stated by Justice Logan in *Millar v Bornholt* [2009] FCA 637:

The right of redress is one of the checks and balances within a disciplined armed force designed to ensure that, on complaint, that ethos will be brought to bear in the scrutiny of action which has occasioned the complaint and in ensuring that whatever action is necessary and appropriate to address the complaint which is found justified will be taken.³³⁹

460. While ROG has a lengthy history, it had also become complex and a potentially lengthy process in the ADF.
461. Prior to 2016, an ADF member who had a grievance could make a complaint to their commanding officer, and if the member was not satisfied with its resolution, they could refer it to their service chief and, in certain circumstances, to the CDF.

462. Following the *Re-Thinking Systems of Inquiry, Investigation, Review and Audit in Defence* review, which was finalised in 2014, changes were made to ROG process in the ADF.
463. The multi-layered ROG review process, which was managed by Complaints Resolution in Defence, was considered complex and inefficient. It could take a long time for a complaint to be finalised. According to one submission we received, the time required to finalise a complaint in the old ROG system was nearly five years.³⁴⁰
464. With a view to reducing timeframes and providing for external oversight, a new, single-layer ROG system set out in Part 7 (sections 38–48) of the Defence Regulation came into effect on 1 October 2016. The new system gave the Inspector-General an oversight function in relation to ROG complaints.³⁴¹
465. It was put to us that the current ROG system is intended to be ‘flexible’ as to the roles played by command and the Inspector-General in dealing with a complaint.³⁴²
466. Under Part 7, ROG complaints are to be made to a commanding officer (or an authorised complaint recipient), who may:
- consider the complaint
 - take action to redress the complaint
 - refer the complaint to another person for consideration or to another person who is capable of redressing it, or
 - refer the complaint to be dealt with under another complaint-handling procedure.³⁴³
467. Within 14 days of receiving a ROG complaint, the commanding officer must ‘refer’ the complaint to the Inspector-General,³⁴⁴ who then ‘considers’ the complaint.³⁴⁵
468. As was explained to us, ‘referral’ of a complaint to the Inspector-General does not mean that *responsibility* to consider the complaint passes to the Inspector-General. In some circumstances it might do so – for example, in cases where it would not be appropriate for anyone in the chain of command to consider it.
469. In the majority of cases, however, a ROG complaint is substantively dealt with by the member’s commanding officer or otherwise within the chain of command, with subsequent review by the Inspector-General.³⁴⁶
470. ‘Referral’, therefore, effectively amounts to notification to the Inspector-General that a complaint has been made. Following this, the Inspector-General typically consults with the relevant commanding officer to determine how the complaint should be handled, and by whom.³⁴⁷

471. There are processes in place for referrals. If the member inserts their commanding officer's name and email address correctly on the Application for Redress of Grievance form, it will automatically go to the Inspector-General when submitted, after which the Inspector-General will engage with the unit in relation to the referral.³⁴⁸ Nevertheless referrals do not always occur in the required timeframe.³⁴⁹
472. In considering a complaint, the Inspector-General may adopt any procedure that they consider appropriate in the circumstances.³⁵⁰
473. Under section 46 of the Defence Regulation, the Inspector-General has the power not to consider or to stop considering a complaint, including where, in the Inspector-General's opinion:
- the commanding officer or authorised complaint recipient has satisfactorily resolved the complaint or will be able to do so
 - the complaint has already been considered
 - it would be more appropriate for the complaint to be dealt with under another complaint-handling procedure
 - the complaint is frivolous or vexatious, or
 - consideration of the complaint is not warranted 'having regard to all the circumstances'.³⁵¹
474. Section 45 of the Defence Regulation provides that after considering a complaint, the Inspector-General must inform the commanding officer or a more senior officer in the member's chain of command of the Inspector-General's findings. The Inspector-General may also inform other people, including the CDF and the member.³⁵²
475. Section 45 also provides that after considering a complaint, the Inspector-General may give a report about the complaint including findings and any recommendations as to actions that the Inspector-General considers should be taken to redress the adverse or detrimental effect of the decision, act or omission.³⁵³
476. Chapter 6 of the *Complaints and Alternative Resolutions Manual* is the Defence policy document that relates to the handling of ROG complaints.³⁵⁴
477. In recent years, the number of ROG complaints submitted annually has been decreasing, although the number remains significant:
- 360 were submitted in 2018–19
 - 318 were submitted in 2019–20
 - 269 were submitted in 2020–21
 - 261 were submitted in 2021–22.³⁵⁵

478. If a member is not satisfied with the resolution of a ROG complaint, their principal recourse is to request that the Inspector-General reconsider it, or to make a complaint to the Defence Force Ombudsman.³⁵⁶ Otherwise the option for a member is to seek judicial review of the decision.

479. Various matters about the ROG process have been asserted to us.

480. For example, one submission author said that the process:

is another redesigned system to not benefit the soldier but protect the leadership ... Taking issues to the IGADF level only delays the inevitable ... the process does not remedy grievances but does contribute to the feeling of hopelessness felt by many.³⁵⁷

481. In another submission, it is said that the ROG process 'lacks independence and favours military Command rather than personnel'.³⁵⁸

482. In a further submission, a former member claimed that they had been told by the Inspector-General that he was 'only there to ensure the process runs smoothly ... through the chain of command'.³⁵⁹

12.4.2 ROG complaints concerning termination of service

483. One of the areas of focus in this report has been termination of service decisions pursuant to section 24(1) of the Defence Regulation. This is because, as detailed in Chapter 10, The ADF military justice system, involuntary termination of service is a risk factor for suicide.

Consideration by the Inspector-General

484. ROG complaints often concern decisions made to terminate a member's service. Since 1 July 2018, termination of service decisions has been the largest single category of ROG complaints,³⁶⁰ accounting for between 23% and 39% of ROG complaints made each year.³⁶¹

485. Termination is a turbulent time in an ADF member's life. The ROG process in relation to a termination decision can compound this stress, and can leave the member in limbo.

486. Witness MB1 gave evidence that their ROG complaint concerning a termination of service decision was pending for more than 850 days. They reported being left with 'a sense and feeling of a void of knowing what's coming or that anyone's actually taking your concern seriously'. In witness MB1's case, they said any meaningful outcome had gone because they had separated from service.³⁶²

487. The Director of the DMRR, who gave evidence at Hearing Block 11, accepted that the time taken for complaints to be dealt with and the inherent nature of the ROG process can cause stress for members.³⁶³

488. Members have no right for the decision regarding termination of their service to be suspended while a ROG complaint is being considered. This can compound the stress and trauma they experience.³⁶⁴ A member's service may be terminated before consideration of their complaint is concluded. If the Inspector-General makes a finding in favour of the complainant, the member may then need to assess whether to return to service months – possibly many months – after being unfairly separated.³⁶⁵
489. ROG complaints concerning termination of service decisions rarely result in an outcome favourable to the member.
490. Information provided to the Royal Commission by the Inspector-General showed that from 1 January 2020 to 7 July 2023, 190 ROG complaints relating to involuntary termination of service decisions pursuant to section 24(1)(a) (member medically unfit for service) or 24(1)(c) (retention of service not in the interests of the Defence Force) were referred to the Inspector-General.³⁶⁶
491. The vast majority of the 190 ROG complaints concerned decisions made under section 24(1)(c), even though during the same period there were around six times more terminations on medical grounds than section 21(c) terminations.³⁶⁷
492. Of the 190 ROG complaints, 172 had been finalised, and for 154 of them (about 89%), the Inspector-General had decided not to consider, or to stop considering, the complaint. According to the summary reasons given to us, in most instances, this was because:
- command had satisfactorily resolved the complaint
 - the decision to terminate was 'open and available' to command
 - command had considered all the evidence
 - the decision was not procedurally unfair
 - the processes applied by command had been correct, and/or
 - the decision was not unreasonable, was reasonable, or was within the bounds of reasonable decision-making.³⁶⁸
493. Where it was said that command had 'satisfactorily resolved the complaint', the summary reasons given to us regarding this conclusion in a number of cases did not suggest a favourable outcome for the member. For example, the summary reasons included that:
- the 'Assistant IGADF consider[ed] the reason for termination to be reasonable and could not find any procedural fairness issues'
 - '[f]urther review would not result in a different outcome'
 - '[a]dmin action open to [commanding officer] to make, procedural fairness provided, process correct, [termination of service decision] open to COMTRAIN to make'
 - '[commanding officer's] consideration of the complaint is comprehensive, well considered and reasonable in the circumstances. It is agreed the member has provided no grounds for the delegate to reconsider their decision'.³⁶⁹

494. Even in the 18 ROG complaints for which the Inspector-General did *not* exercise the power ‘not to consider or to stop considering a complaint’, a number had findings that suggested the outcome was not in favour of the member, including findings such as the decision complained of being ‘reasonably open on the evidence’.
495. The Director of DMRR accepted that in the 2021–22 year, there were no ROG complaints concerning termination of service decisions that were found in favour of the member with a recommendation being made for redress.³⁷⁰
496. ROG complaints often do not result in outcomes favourable to the member. For example, in 2021–22, 226 complaints were concluded. Using the Inspector-General’s categories, of these:
- 116 were found to have no merit
 - 31 were withdrawn by the member
 - 12 were considered outside the ROG system
 - 45 were partially or fully upheld
 - 22 were resolved administratively outside the ROG process.
497. If ‘withdrawn complaints’, ‘complaints outside the system’, and ‘complaints resolved outside the process’ are excluded, around 72% of completed ROG complaints were found to be of no merit.³⁷¹
498. Part of Hearing Block 11 was devoted to obtaining an understanding of the approach taken by the Inspector-General when considering ROG complaints, particularly ROG complaints concerning termination of service decisions.
499. The Inspector-General’s powers themselves are exercised by the Director and other DMRR staff as Assistant Inspectors-General with authorisation to sign off on ROG decisions.³⁷²
500. What emerged is that there is typically no review in the nature of a merits review whereby the facts and circumstances are reconsidered in order to determine whether the decision complained of is the correct or preferable one. Rather, what appears to happen in most cases is that a decision not to consider (or to stop considering) the complaint is made by reference to whether, for example:
- the decision was consistent with relevant legislation and Defence policy
 - the decision was ‘open to be made’ on the evidence
 - the decision was within the bounds of reasonable decision-making
 - all relevant evidence was considered
 - there was procedural unfairness.³⁷³

501. The Director of the DMRR accepted that when discharging the Inspector-General's function there was no impediment to undertaking a merits-style review that does not involve a power to *replace* the decision complained of – the Inspector-General does not have this power – but would allow for the Inspector-General to recommend that the decision be set aside if this would be considered the correct or preferable outcome.³⁷⁴
502. In our view, a review in the nature of a merits review should be incorporated in the Inspector-General's approach to termination of service ROGs.
503. A practical consequence of proceeding this way may be that fewer ROG complaints concerning termination of service decisions would be concluded on the basis of section 46 of the Defence Regulation – that is, on the basis of the power not to consider or to stop considering a complaint.

Independent oversight

504. Undertaking a merits-style review as we have proposed will likely further the objective of the current ROG process that the Inspector-General provide independent oversight of Defence decision-making.
505. In the context of ROG complaints, and particularly where ROG complaints concern the decision to terminate a member's service, there is a further step that the Inspector-General might consider taking before finalising particular complaints; namely, having the soundness of the decision they propose to take reviewed by a qualified legal practitioner who is independent of Defence and of the Inspector-General.

12.4.3 Timeliness

506. It is clear from the evidence we have seen that overall timeframes for resolving ROG complaints are on average significantly less under the current ROG process than under the old ROG system. This is particularly the case where higher-level reviews were conducted under the old system.³⁷⁵
507. According to a presentation given by the Director of the DMRR, in the period from October 2016 to February 2023, the average and median timeframes from submission to closure of ROG complaints were 100 and 84 days respectively. These timeframes included consideration at the unit-level and by the Inspector-General. For ROGs submitted under the old system, the average and median timeframes were 116 and 80 days for unit-level consideration, 498 and 463 days for service chief-level referrals, and 818 and 830 days for CDF referrals.³⁷⁶
508. As the Director of the DMRR acknowledged, timeframes for resolution of ROG complaints under the current ROG process are still substantive.³⁷⁷
509. We have already referred to the stress and other negative effects that can be caused by the time taken for ROG complaints to be dealt with, including ROG complaints concerning termination of service decisions.

510. From information provided to us by the Inspector-General, many ROG complaints concerning termination of service decisions appear to be finalised within the average timeframes, but there are a number that are not.³⁷⁸ We have seen examples where the time taken is considerably longer.³⁷⁹
511. There do not appear to be any KPIs concerning timeliness in relation to the finalisation of ROG complaints, save for what appears in the IGADF Strategic Plan 2023–2025. The plan includes the goal to ‘monitor the effectiveness of all complaint handling within the ADF’, and the strategy refers to ‘continually seek[ing] to reduce the time taken to finalise ... redress of grievance’. There is also a goal to ‘improve timeliness’, with the following as a goal measure:
- [that] once all documentation for a complaint under the redress of grievance scheme is received, 85 per cent of ROG complaints will be finalised within 90 days after IGADF takes sole carriage of the complaint.³⁸⁰
512. This specifies the starting date for resolution of a complaint as the date the Inspector-General takes ‘sole carriage’ of the complaint. From examples we have seen, it appears that with termination of service ROGs, the Inspector-General typically takes carriage of the complaint, given that the termination decision itself will have been made by a delegate of the CDF within the Career Management Agency (in Army) or equivalent in the other services.³⁸¹
513. In our view, where ROG complaints concern termination of service decisions, the Inspector-General should, to the greatest extent possible, ensure that the complaint is finalised within 60 days of the date on which they take sole carriage of the complaint.
514. In all other cases, the Inspector-General should seek to finalise ROG complaints within 90 days of referral.
515. A related matter is the cut-off period in which a member has to make a ROG complaint in relation to a termination of service decision pursuant to section 24(1) of the Defence Regulation. It is only 14 days from the date on which the member is notified of the decision, whereas it is six months for other ROG complaints.³⁸² No scope exists to vary or extend this timeframe,³⁸³ although the Director of the DMRR told us of one occasion where he had used creative means to ‘get around it’.³⁸⁴
516. Given the seriousness of a termination decision and the stress it can put on the member, we believe 14 days to be inadequate. This is particularly so given that members may wish to obtain legal assistance in preparing a ROG application, and additional time will assist them in doing that.
517. There can be challenges, for example, in getting assistance from a DCS legal officer within such a tight timeframe.

518. Extending the time period would also bring greater fairness to a member, given that under the Defence Regulation a member must respond to a notice of termination within 14 days, yet there is no time period prescribed for the CDF (or their delegate) to make the termination of service decision.
519. Members should have 21 days in which to make a ROG complaint concerning a termination of service decision.

12.4.4 The structure and processes of the DMRR

520. In addition to the Director, the DMRR consists of permanent staff drawn from the ADF and from the APS. As at 20 May 2022, there were seven permanent staff, of which four were on postings from the ADF.
521. The DMRR is also assisted by reservists, and on occasion by external law firms as consultants.³⁸⁵

Quality control and assurance processes

522. As discussed earlier in this section, decision-making in relation to ROG complaints is delegated to the Director and staff in the DMRR. However, the Director does not sign off on every outcome letter that goes out.³⁸⁶
523. The Director explained there is no review of a decision-maker's decision by another person, with one person making the decision that goes out, although there might be occasion for discussion with the Director if they wish to do so.³⁸⁷ The Director said that he relies on the professional judgement of the small group of decision-makers in the DMRR, and trusts that if they have any concerns, they will communicate with him and discuss it. He told us it is 'almost unheard of for a decision-maker to make a decision in isolation without talking to other people and bouncing ideas [around]'.³⁸⁸
524. The Director also said there was no formal governance system in the DMRR to oversee the quality of the responses that go out, and that the oversight system that exists is limited to the Director's judgement as to who on the DMRR staff should handle a particular complaint.³⁸⁹ He said that he struggled to see what quality control might entail 'beyond training'.³⁹⁰
525. This arrangement does not strike us as satisfactory quality control or assurance in decision-making, particularly where decisions can have a significant effect upon members' careers, and their wellbeing.
526. The situation is further compounded by the fact that there is no comprehensive guidance manual or standard operating procedure in the DMRR, covering (for example) DMRR processes and how the Inspector-General's powers are to be interpreted and applied in decision-making.³⁹¹ This is despite the DMRR having been established in 2014 and having assisted the Inspector-General in discharging the Inspector-General's function in relation to new system ROG's since 2016.

527. As the Director acknowledged, there are no formal policy documents in the DMRR to give guidance as to how complaints should be dealt with,³⁹² or that speak to the construction of (for example) section 46(1)(a) of the Defence Regulation.³⁹³ Nor are there policy documents about engaging with complainants,³⁹⁴ communicating with members when exercising section 46(1)(a) powers,³⁹⁵ or what matters to take into account when deciding whether further consideration of a complaint is not warranted.³⁹⁶
528. At the time of giving evidence, the Director said he was working on a directive for communications when section 46(1)(a) powers are exercised.³⁹⁷
529. Since Hearing Block 11, we have been told of certain governance arrangements that the Director did not address in his evidence but that exist in the DMRR concerning consideration of ROG complaints by DMRR staff.³⁹⁸
530. We have also been told that while evidence at Hearing Block 11 focused on the review of decisions in relation to ROG complaints by the relevant member of the DMRR staff, the evidence 'did not cover quality assurance processes embedded in the analysis and development of outcomes letters for signature',³⁹⁹ and that the process of finalising a ROG complaint involves progressive interactions between a case officer, the Deputy Director of the DMRR, and another senior case officer, before a draft decision is allocated to a decision-maker (EL2/06) for final review and signature.⁴⁰⁰
531. While these matters are relevant, quality control and assurance is clearly an area for improvement. This would also likely enhance confidence in the Inspector-General. There needs to be comprehensive guidance in relation to the DMRR's processes that details how the Inspector-General's function of considering ROG complaints is discharged, with formalised processes to ensure quality assurance in decision-making.

Engaging with members

532. The practice in the DMRR appears to be that a standard form email is sent to a member confirming that the member's ROG complaint has been received.⁴⁰¹ At the end of the process, members must be informed in writing when a decision has been made not to consider, or to stop considering the complaint under section 46 of the Defence Regulation.⁴⁰² The member must also be told in writing of findings made if the Inspector-General considers the complaint pursuant to section 45.⁴⁰³
533. As to what occurs in between, the Director told us that engagement with members varies by complaint, and that while there has always been direct contact on an 'as-needed' basis, the DMRR since around 2020 or 2021 has sought to increase engagement with members as a form of 'continuous improvement'. The purpose of this was to glean whether the member was satisfied or otherwise with the commanding officer's decision in relation to the grievance, and to give members an opportunity to provide additional information and identify whether there is anything specific they want the Inspector-General to address.⁴⁰⁴

534. The Director explained to us the impetus for this increased engagement:

It's been a graduated increase over time. I think there's been an increase in the complexity of complaints over time. There's been new ideas from staff members that have come in ... So internal discussions, internal training, of implementing that [communication], and increasing it. The Inspector General and I have had discussions, as we do quite regularly, about looking for ways that we could increase the satisfaction of complainants.⁴⁰⁵

535. There is no formal assurance process completed to monitor this continuous improvement.⁴⁰⁶

536. In our view, it is important that engagement of this kind occurs in relation to *all* ROG complaints referred to the Inspector-General.

537. Further, after initial contact has been made concerning a ROG complaint, a member should be encouraged to provide any further information that may be relevant to the complaint, or that the DMRR case officer considers may be of assistance.

538. In relation to ROGs about the termination of a member's service, where it is proposed that an outcome will be reached that is not favourable to the member, they should be given the opportunity to provide any further information or submissions prior to the Inspector-General concluding consideration of the complaint. Where practicable, members should be able to provide this further information in person.

539. Members should also receive regular and meaningful updates on the progress of a ROG complaint. We have been told by the Inspector-General that since Hearing Block 11, 'complainants [have] receive[d] an email update from desk officers every other month'.⁴⁰⁷ If this is the practice, we endorse it, particularly as we heard evidence of where meaningful updates had not been provided.⁴⁰⁸

Staffing

540. We have already discussed the DMRR's staffing challenges. The Director made it plain that more staff with the right qualifications are needed.⁴⁰⁹

541. We have been told that since Hearing Block 11:

- two additional permanent APS EL1 senior case officers have started at the DMRR
- in response to the services not being able to fill positions, plans have been made to recruit up to six further permanent APS case officers
- external law firms have remained engaged to assist with caseloads until permanent staff are engaged and trained
- additional reservists are being sought
- the ADF Navy Desk officer position in the DMRR has been 'civilianised' to address Navy posting limitations, and that this position was filled by a permanent APS6 on 12 March 2024.⁴¹⁰

542. These are positive developments, and are consistent with the restructuring that we have recommended to diversify the Office the IGADF workforce. We are not in a position, however, to assess whether this is enough for the DMRR to resolve its resourcing issues.

Training

543. Given the stress that can be associated with ROG complaints, particularly those concerning termination of service decisions, it is important that trauma-informed practices are followed by staff in the DMRR when engaging with complainants.
544. As we have recommended for the DSIR, staff members of the DMRR and consultants who are involved in the consideration of ROG complaints should complete the Compassionate Foundations course, or equivalent, before they do this work. Refresher training should also be completed every two years.

12.5 The DMJPR: audits at the unit level

545. A core function of the Inspector-General is to conduct performance reviews of the military justice system.⁴¹¹ This function is specified under section 110(1)(c) of the Defence Act.

12.5.1 The audit program of the DMJPR

546. The principal way this function is discharged is through a well-established audit program of ADF units administered by the DMJPR, a directorate of the Office of the IGADF.
547. Audits are to review the health and effectiveness of the military justice system at the unit level. They also include an assessment of how the ADF is managing mental health and suicide (including suicide ideation) in the context of the military justice system.⁴¹²
548. The DMJPR has a Director (a Level 06 ADF legal officer), and permanent staff consisting of two ADF members and three APS employees. It also draws upon reserve ADF members, who make up around 80% of auditors.⁴¹³
549. Audits are conducted by an audit team, which usually consists of four DMJPR staff. All staff are appointed as Assistant Inspectors-General.⁴¹⁴ Auditors wear civilian business attire when conducting audits.⁴¹⁵
550. The DMJPR aims to conduct around 60 audits (around 13% of all ADF units) each year.⁴¹⁶ The actual number, however, tends to be closer to 50. In 2021–22, 41 audits were conducted, with COVID-19 restrictions having an impact.⁴¹⁷

551. There are four types of audits:

- ‘Routine Audits’, which examine a unit’s record of military justice activities in the previous 12 months and assess compliance with military justice law and Defence policy.
- ‘Targeted Audits’, which are done when information received indicates that there may be military justice problems in a unit.
- ‘Comprehensive Audits’, which are uncommon, and examine all military justice activity of a unit in the previous two years and assess whether previous audit or inquiry recommendations have been properly implemented.
- ‘Re-Audits’, which occur where a unit is assessed in a Routine Audit or Targeted Audit as having material deficiencies in military justice arrangements, and are to assess whether command has corrected the deficiencies that were identified. Re-Audits are conducted within 12 months of the original audit.⁴¹⁸

552. Of the 41 units audited in 2021–22, four were found to have material deficiencies and were thus re-audited.⁴¹⁹

553. Reports of Routine Audits contain extensive information about a unit, including:

- the unit’s awareness of and compliance with laws, policies and procedures relating to the administration of military justice
- the extent to which units have necessary procedures and processes in place for effective delivery of military justice
- any deficiencies and shortfalls in military justice procedures and processes, and in relevant training
- incidents of unacceptable behaviour, ROG complaints, and suicidal episodes that have been identified.

554. Serious issues in units can be identified through a Routine Audit. For example, the 2022 audit of one regiment that we examined in our Perth hearings identified significant and continuing issues of ill-treatment, sexual misconduct and unacceptable behaviour towards women of all ranks, and that while there was high confidence in the commanding officer, there was a lack of confidence across the unit that command at every level would treat complaints seriously or manage them in accordance with contemporary management standards.⁴²⁰

555. Audits can provide an early warning of unit-specific issues with potential military justice impacts.⁴²¹

556. Focus group discussions and focus group surveys are key features of audits. They are conducted for the purpose of hearing the views and opinions of command and members on military justice issues within the unit. Separate focus group discussions are held with the command group and with members who are posted to the unit. The focus group held with members seeks to ascertain members' views on how the unit's command group administers, implements and manages military justice in the unit.
557. Focus group discussions are 'useful indicators of the military justice system and culture' within units.⁴²² Discussions with members are often broken down by rank and gender to encourage frank discussion.⁴²³
558. In 2021–22, there were 2,766 members (137 from the Navy, 1750 from the Army, 802 from the Air Force, and 77 from Joint) who attended focus group discussions. In the previous year, the number was 3,558.⁴²⁴
559. Focus group participants are asked to complete an anonymous survey of 38 questions covering a wide range of matters including:
- their knowledge of military justice processes
 - their views on the effectiveness of the military justice system
 - their familiarity with complaint processes
 - their views on the timeliness of military justice actions
 - their confidence in command
 - whether they have experienced or witnessed unacceptable behaviour
 - whether they believe members are treated fairly
 - whether they believe all ranks and genders are treated equally
 - their views on workload and morale.⁴²⁵
560. While only a subset of unit personnel may attend a focus group discussion and complete a focus group survey, the responses, which are included in the unit audit report, are a valuable source of information. They help monitor how military justice is handled at the unit level, and provide indications of the culture and wellbeing of the unit more generally.
561. Audit reports make recommendations and suggestions. Significantly, recommendations made in audit reports are mandatory. The Inspector-General told us that:
- [u]nless compelling reasons exist not to do so, it is mandatory for units to implement recommendations, because units are required to comply with military justice law and policy.⁴²⁶

562. Suggestions in audit reports concern matters not mandated by military justice law and policy, but rather ‘represent good practice drawn from IGADF experience’.⁴²⁷ Unit commanders have discretion as to whether to implement them.

12.5.2 The audit cycle of the DMJPR

563. Given the high value of the information gathered in audits, in our view there should be more of them.

564. Under the audit cycle of the DMJPR:

- major ADF units are audited every four to five years
- *ab-initio* training establishments are audited every two to three years, as trainees are young and some of the most vulnerable ADF personnel. They may not be aware of avenues for complaints or be reluctant to complain
- for reasons associated with the conclusion of the Afghanistan Inquiry, Special Operations units are audited every two years.⁴²⁸

565. Major units are units, ships, establishments or groups with more than 50 posted personnel with a commander at the O5 or O6 rank.⁴²⁹

566. Smaller units are audited when the Inspector-General directs an audit, or when one is requested by the relevant service.⁴³⁰

567. In our view, routine audits of major ADF units should be conducted every three years. Four or five years between audits is a long time. It means that toxic culture and poor practices can take hold, increasing the risk of negative behaviours and conduct that reduce the wellbeing of members in the unit.

568. Ab-initio training establishments should also be audited more regularly, given the cohort involved. Audits of these establishments should occur every two years.

569. There is no reason to assume that poor practices and a toxic culture are unlikely to be found in small units; in some ways, they may have a heightened risk. The Inspector-General should aim to audit at least three small units every year. This should be in addition to when the Inspector-General directs or a service requests an audit of a small unit. The three small units might be selected randomly, or they might be indicated by some feature that warrants an audit occurring – for example, complaints being made.

570. We recognise that the Inspector-General will have to be further resourced in order for the DMJPR to administer an amended audit cycle program.

12.5.3 Audit information

571. Survey results from focus group participants are compiled in individual unit audit reports and compared with the service average for each of the 38 questions in the previous financial year.
572. In the Inspector-General's annual Statistics Catalogues, average survey responses for the 38 questions are grouped by service, and the results from previous years are presented for comparison. Overall outcomes of audits are also summarised in the Inspector-General's Annual Reports and Statistics Catalogues.
573. This information, together with other information included in audit reports – such as serious issues that are identified, and details about how mental health and suicide including suicide ideation is being managed by units in the context of the military justice system – is immensely valuable.
574. We have also reviewed the *Analysis of IGADF Military Justice Performance Audit Reports* over the period 1 January 2021 to 30 September 2022 that was prepared by SSIM in ADFHQ.⁴³¹ This analysis is known as the Assurance Check Report 22-47.
575. Assurance Check Report 22-47 provides an analysis of the recommendations in 63 Inspector-General audit reports to identify trends and recommend short-term remediation actions to address the most common deficiencies identified in the disciplinary system and in the administrative system in units in the ADF.
576. The significance of a report like Assurance Check Report 22-47 is that it underscores how the extensive information contained in audit reports can be used beyond identifying actions for individual units.
577. In our view, the Inspector-General should conduct a longitudinal analysis of all audit reports every two years to determine themes, trends and issues of concern – for example, if there are clusters of unacceptable behaviour or poor culture beyond individual units at particular barracks or in a certain region. This should be done by the Inspector-General irrespective of any work otherwise done within the ADF, including by ADFHQ. The reports of the longitudinal studies should be provided to the CDF.
578. This sort of analysis assists in identifying emerging issues or trends that contribute to suicide or suicidality, such as increases in unacceptable behaviour or sexual misconduct.
579. Analysis of this kind might also yield valuable observations like those made by the Inspector-General in a memo to the CDF in July 2020 in which he said that, on the basis of audit survey data collected over four years from 13,574 members in 213 units, the incidence of unacceptable behaviour in a unit is likely to be lower if members are confident their command will act on complaints.⁴³²

12.6 The DII: when the military justice system falls short

580. Conducting inquiries into alleged failures of military justice in the ADF is another core function of the Inspector-General.⁴³³ The DII within the Office of the IGADF assists the Inspector-General in conducting such inquiries.⁴³⁴
581. The inquiry function is critical as it provides a principal means for members to complain about matters such as unacceptable behaviour, including bullying, harassment and inappropriate behaviour; sexual violence; abuse of authority; abuse of process and failures to act; and how complaints have been managed under normal avenues of complaint, outside of members' chain of command. Complaints are often concerned with matters that go to the wellbeing of members, and can be associated with matters that are suicide risk factors.
582. The DII also assists with the Inspector-General's added function of investigating complaints relating to service police officers pursuant to section 5(c) of the IGADF Regulation.
583. Inquiries may be conducted at the request of an individual through the making of a complaint or submission, or on the Inspector-General's own initiative.⁴³⁵
584. The Inspector-General may also be directed to inquire into or investigate a matter concerning the ADF by the CDF or the Minister.⁴³⁶
585. Several issues arise in relation to the Inspector-General's inquiry function.
586. We have already discussed perceptions that the Inspector-General is not sufficiently independent of Defence in the discharge of the role's functions, including the function of inquiring into military justice failures, and have referred to steps that the DII has taken to combat such perceptions.
587. In addition, relatively few complaints by members go further than what is referred to as a preliminary assessment, and do not proceed to an inquiry by the Inspector-General.⁴³⁷ The time taken to conduct preliminary assessments and inquiries can cause stress to complainants and others involved, and the time taken to complete an inquiry can be very lengthy.⁴³⁸ Concerns have also been raised with us about whether all relevant matters complained about are considered in an inquiry conducted by the DII, and about communications during the inquiry process.
588. We discuss these matters in this section.

589. We have also referred earlier in this chapter to the 2021 Complainant Feedback Survey in relation to the DII conducted by an external private research company.⁴³⁹ The survey was offered to 100 people who had made a complaint or submission to the Inspector-General in the preceding three years. Thirty-two responded. While the number of respondents was limited:

- 31% of the participants were satisfied with the way their complaint had been handled
- 64% disagreed that the entire inquiry process was completed in a timely manner, with 50% strongly disagreeing
- 50% strongly disagreed that they had been kept informed of the inquiry's progress
- 61% of complainants whose complaints were resolved at the assessment stage strongly disagreed that they were satisfied with the way their complaint was handled
- 56% of the participants who had their complaints closed at assessment, and 57% of those whose complaints proceeded to inquiry felt that, disregarding the outcome of their inquiry, they had been had treated fairly
- 35% felt that the person who handled the inquiry was impartial and non-judgemental, while 36% strongly disagreed that this was the case.

590. These results provide some context for several issues we discuss in this section.

12.6.1 Overview

591. In 2021–22, 94 complaints or submissions were received by the Inspector-General, which compares with the historical average of 64. There were 116 complaints and submissions received in the previous year.⁴⁴⁰

592. Complaints or submissions are largely from existing ADF members, although they are also received from former ADF members, families, APS staff and members of the public.⁴⁴¹

593. Complaints or submissions can also be referred from the ADF or Department of Defence, or, more rarely, another government agency.⁴⁴² They may also be referred on occasion from within the Office of the IGADF, for example where a complaint is made by a member as a ROG complaint, but it is assessed within the office that the complaint should not be dealt with that way.⁴⁴³

594. The Inspector-General categorises complaints received. The largest category in 2021–22 was complaints about unacceptable behaviour (about 38% of complaints were about this). The other main categories regarded abuse of authority, abuse of process, avoidance of due process and failures to act.⁴⁴⁴ Complaints are also received concerning matters such as health care and policing issues.⁴⁴⁵

595. Often a complaint by a member about unacceptable behaviour is overlaid with a complaint about the way the complaint was dealt with by command, so that what the Inspector-General is tasked with reviewing is the action or inaction taken by Defence.⁴⁴⁶ However, ADF members may also complain directly to the Inspector-General without first taking their complaint to their chain of command.
596. The Inspector-General's inquiries function under section 110C(1)(a) of the Defence Act includes carrying out preliminary assessments as to whether an inquiry or investigation should be conducted in relation to a complaint or submission.⁴⁴⁷
597. Assessments are conducted by DII case officers who are assisted by DII assessments staff.⁴⁴⁸
598. Inquiries, on the other hand, are conducted by Assistant Inspectors-General under the IGADF Regulation on behalf of the Inspector-General.
599. Assistant Inspectors-General are usually ADF reservists, although occasionally contractors are used because the subject matter suggests that particular expertise is needed or because a conflict of interest might be perceived. Of the 115 matters the DII had open in 2023, only four were being handled by consultants.⁴⁴⁹
600. An inquiry may also be conducted by an Assistant Inspector-General who is a judicial officer. These inquiries are conducted under Division 4A Part 4 of the IGADF Regulation, and they are significantly different from other inquiries. The judicial officer conducts the inquiry in the way they consider appropriate, and does not act under the direction of the Inspector-General. The Inspector-General must not take part in inquiries of this kind or give directions about them and the judicial officer must not help the Inspector-General carry out any other function.⁴⁵⁰
601. There have been very few inquiries conducted by a judicial officer. The principal one is the Afghanistan Inquiry, which was an inquiry conducted pursuant to a direction by the CDF.

12.6.2 The DII

602. The DII has a Director (who is a 06 legal officer) and permanent staff including a Deputy Director of Inquiries and Investigations (a 05 legal officer), a Deputy Director of Assessments (a 05 legal officer), a Deputy Director of Professional Standards (a 05 legal officer) and a Legal Officer (APS EL1).⁴⁵¹ At the time of Hearing Block 11, there were about 11 permanent staff members.⁴⁵² In addition to these, the DII calls upon a pool of ADF reservists, shared with the DSIR, to conduct inquiries.⁴⁵³ All staff including contractors are appointed Assistant Inspectors-General so they can carry out the functions of the Inspector-General.⁴⁵⁴

603. More than half of the permanent or full-time DII staff members are on postings from the ADF. As with other Office of the IGADF staff, ADF members are typically posted to the DII for two or three years. The Director of the DII, who gave evidence at Hearing Block 11, was an exception. She had been posted to the Office of the IGADF since 2019. Reservists tend to stay for many years. APS staff members are ongoing employees with no fixed term.⁴⁵⁵
604. Permanent staff of the DII conduct assessments, scope inquiries, coordinate the conducting of inquiries and support Assistant Inspectors-General with inquiries. Permanent staff are also responsible for conducting investigations and assessments in relation to military police professional standards.⁴⁵⁶ The role of the DII Legal Officer is to review proposed findings to check that they are legally supported.⁴⁵⁷
605. The DII has a comprehensive standard operating procedure in the form of the *Directorate of Inquiries and Investigations Assistant IGADF Handbook* (the DII Handbook).⁴⁵⁸
606. The Director told us she created the first version of the DII Handbook after she was posted to the Office of the IGADF as the Director of DII in the middle of 2019. She said she did so because when she arrived at the DII, she was given 110 pages of ‘handover notes’ by her predecessor to explain how to do her job. Previously, the only guidance for DII staff in how they should undertake their functions was through verbal briefings from the Director.⁴⁵⁹
607. It is surprising that there was not a DII Handbook before the Director created it.⁴⁶⁰
608. The DII Handbook is described as ‘non-binding and continually updated guidance on the conduct of IGADF inquiries’.⁴⁶¹
609. The Director described the DII Handbook as a ‘living document’, and told us that all DII staff have the ability to go into the document and change it where they notice something that is not current or up to date with procedures. Changes do not have to be first put through the Director or the Inspector-General. The Director said that there are no standard operating procedures in relation to making changes, and reviews of changes only occur if the Director reviews the DII Handbook’s table of amendments.⁴⁶²
610. While this process avoids any delays that might be caused if clearance and approval processes are needed before changes are made, it does raise concerns about quality assurance. These should be addressed by documenting processes and by the Director regularly approving amendments.

12.6.3 Staffing

611. According to the Director, there are two core sets of skills considered important when ADF reservists are selected for DII work. The first is technical skills, meaning people ‘who have inquiring minds and who can write clearly and well’. The second is staff ‘with strong people skills’, given that complaints ‘at their heart, are about people’.⁴⁶³

612. There are no mandatory qualifications for reservists to be Assistant Inspectors-General and conduct inquiries, although there is an expectation that they have, or are working towards, their Certificate in Government Investigations. Backgrounds are mixed. Some are lawyers, but the majority do not have legal backgrounds.⁴⁶⁴
613. All staff who conduct Inquiries are enrolled by the DII on the Advanced Inquiry Officer course offered through the Military Law Centre.⁴⁶⁵
614. Given the nature of many complaints and submissions that are made to the Inspector-General by members of the ADF, and the stress that often goes along with that – including for those who may be implicated – the DII is another area where trauma-informed practices when engaging with members is particularly important, as is training in relation to such practices.
615. Information we received suggested that around 56% of DII staff had completed the Compassionate Foundations course or other similar training.⁴⁶⁶ In our view, all DII staff members should do so.
616. As with the other directorates in the Office of the IGADF, staffing and having a sufficient workforce to manage workload is an issue for the DII.
617. We have already referred to evidence from the Director and from Mr Gaynor that the Directorate does not have sufficient resourcing.
618. At Hearing Block 11, the Director told us that recruiting of APS investigators at two different levels was underway, and that the DII was looking to add two or three to its permanent staff.⁴⁶⁷
619. We have since been told that the DII now has a permanent staff of 17, up from 11, with three APS positions vacant and recruitment being undertaken.⁴⁶⁸
620. These are positive developments. Some issues in relation to the discharge of the inquiries function, for example in relation to timeliness, are likely to be related to resourcing.

12.6.4 Assessments

621. Following receipt of a complaint or submission, an automated email is sent to the complainant acknowledging receipt.⁴⁶⁹ This is followed by a second email setting out the DII's role, possible decisions that can be made and the next steps, and noting that a case officer will be allocated to conduct the assessment.⁴⁷⁰
622. Since at least some time in 2022, the case officer has been required to contact the complainant to clarify the complaint and ensure that the right matter is being inquired into, rather than relying only on the complainant's written submissions.⁴⁷¹
623. The case officer then conducts an assessment pursuant to section 110C(3)(c) of the Defence Act.

624. The Director told us that ‘if at all possible, our goal is to resolve the complaint at the assessment phase’.⁴⁷² She said that in her time as Director, around 90% of complaints had been resolved at the assessment phase, and only around 10% of complaints proceeded to a full inquiry.⁴⁷³
625. During the period 11 February 2022 to 10 July 2023, 196 complaints or submissions were received by the DII. Excluding 72 that were still under assessment at the end of the period:
- 86 of 124 complaints (around 70%) were resolved at the assessment stage
 - 19 (slightly over 15%) proceeded to an inquiry
 - 16 were referred to Defence to investigate further
 - three were determined to be outside the Inspector-General’s jurisdiction.⁴⁷⁴
626. Assessments are based on information obtained from the complainant including through telephone interviews and through documents relating to the complaint such as relevant Defence policies, previous Defence fact-finding or inquiry reports, and other reasonably available records.⁴⁷⁵
627. The case officer also considers whether all Defence avenues to resolve the matter have been exhausted.⁴⁷⁶
628. The case officer will then debrief the Deputy Director on their proposed findings and the potential courses of action.⁴⁷⁷ If necessary, the DII Legal Officer conducts a legal review. The draft assessment report goes to the Director, and then the Inspector-General for approval. This is the quality assurance process for the report.⁴⁷⁸

The standard applied

629. As to the way in which complaints or submissions are assessed in order to determine whether an inquiry should be conducted, the Director told us that the standard applied is whether:
- the outcome of the matter complained of was in accordance with legislation and Defence policy
 - the decision or outcome was open on the evidence
 - the decision made was not unreasonable
 - procedural fairness was afforded
 - in the Inspector-General’s view, the outcome was not otherwise unfair.⁴⁷⁹
630. If these criteria are met, the complaint or submission is treated as resolved, and no further action, such as an inquiry, is required.

631. We note that there can be other possible outcomes of an assessment, apart from treating the matter as resolved with no further action required, or determining that an inquiry is needed. These include that:
- no further action is required because it is determined that another agency has responsibility for dealing with the matter
 - resolution action is required because errors are found in Defence's management of the matter
 - the matter should be referred to another authority in the first instance.⁴⁸⁰
632. Given the standard applied, it follows that a matter being 'resolved' at the assessment stage does not necessarily mean that the outcome is to the satisfaction of the complainant, or that the matter is resolved as the complainant would like it to be.⁴⁸¹
633. The Director told us that an assessment does not involve a review in the nature of a merits review, save for where the Inspector-General determines that despite everything being done in accordance with legislation and policy, the outcome is 'really unfair to the individual'. In this circumstance, the outcome of an assessment can be a request that the matter itself be reviewed, 'with some kind of recommendation'.⁴⁸²
634. As noted, only a small number of complaints or submissions proceed beyond the assessment phase to an inquiry.
635. In our view, in certain circumstances the Inspector-General should consider expanding the approach applied when conducting assessments pursuant to section 110C(3) of the Defence Act to the extent necessary to ensure that matters proceed to an inquiry. These circumstances might include where:
- the Inspector-General has concerns about the Defence policy that has been followed or applied in relation to the decision or outcome complained of, including concerns about whether it is good or reasonable policy
 - there is an emerging trend or pattern of complaints about similar failings of military justice
 - on the information available, the correct or preferable decision may not have been made
 - the Inspector-General considers that it may be in the interests of ADF members more broadly if the particular complaint be inquired into.
636. We accept that any broadening of the triaging applied in the assessment phase is likely to increase the number of matters that proceed to an inquiry. If so, the DII would need to be resourced for any increase in work that results.

Timeliness of assessments

637. We have noted that the time taken to complete an assessment and an inquiry can cause stress for complainants and others.
638. The DII Handbook provides that ‘ideally’, the case officer should prepare a draft assessment report for submission to the Deputy Director of the DII within 28 days of the case officer being appointed.⁴⁸³
639. Indeed, the template acknowledgment email provides that a complainant should expect further advice within four weeks of the decision by the Office of the IGADF.⁴⁸⁴
640. The IGADF Strategic Plan 2023–2025 includes a general goal of improving timeliness, and there is a goal measure that assessments be completed within 16 weeks.⁴⁸⁵
641. The Director told us that in preparation for her appearance as a witness, the DII had determined that the average time taken for assessments in the previous year was 50 days from the appointment of a case officer.⁴⁸⁶
642. However, significantly longer periods can be involved. In one matter we heard evidence about, the assessment took around six months to complete.⁴⁸⁷
643. We acknowledge that some assessments may be more complex than others, and the length of time taken to complete them may be impacted by various factors, some of which may be outside the Inspector-General’s control.
644. Nevertheless, in our view, the Inspector-General and the DII should do all that is practicable to ensure that assessments are completed and outcomes are communicated to complainants no later than three months after a complaint is submitted, and sooner wherever possible, and this should be reflected in the DII Handbook.
645. The Director also told us that complainants are told that the DII will endeavour to finish assessments within a month, and if it is not finished within this timeframe, ‘[complainants] will be provided monthly updates’.⁴⁸⁸
646. We have referred earlier in this chapter to the importance of updates that are predictable and frequent. The DII Handbook does not expressly provide for monthly updates, and it should do.
647. We have been told since Hearing Block 11, the DII Handbook will be updated in this regard.⁴⁸⁹

12.6.5 Inquiries

648. As noted, a relatively small proportion of complaints and submissions proceed to an inquiry.

The inquiry process

649. According to the Inspector-General, for complaints and submissions that proceed beyond the assessment phase to an inquiry, the following process occurs:

- (1) An Assistant Inspector-General is appointed to conduct the inquiry and inquiry directions are drafted within the DII. These directions set out the manner in which the inquiry is to be conducted, including any compulsive powers that may be exercised to obtain evidence and documents. The directions include a due date for inquiry completion.
- (2) The inquiry gathers relevant documents and records, conducts witness interviews, and obtains relevant expert evidence as needed.
- (3) After evidence gathering is complete, the Assistant Inspector-General completes a draft inquiry report, which is reviewed in the Office of the IGADF.
- (4) Where a report contains critical comments or findings about individuals, they are sent procedural fairness letters, and the report may be edited where appropriate in light of the responses received.
- (5) A final report is prepared by the Assistant Inspector-General and finalised by the Inspector-General.
- (6) The approved final report is sent to the CDF.
- (7) Outcome correspondence is sent to complainants and potentially affected persons.
- (8) Other inquiry participants are informed that the inquiry has finished.⁴⁹⁰

650. Depending on the nature and scope of the complaint, inquiries can be substantial undertakings and take a long time to complete. The issue of timeliness is discussed further later in this section.

Inquiry directions

651. Captain Shindy gave evidence that she was not consulted by the DII in relation to the directions that were issued for the inquiry into a complaint she had made. She said that, in her view, the directions were too tightly constrained, with matters omitted, which reduced the value of the report.⁴⁹¹

652. The Director of the DII gave evidence that complainants are not typically consulted in the relation to the framing of inquiry directions. This is because complainants are spoken to during the assessment phase, and that as part of that engagement, emails are sent to the complainant seeking confirmation that the issues have been correctly understood. The Director further noted that directions are flexible so that if a new matter emerges, they can be amended.⁴⁹²

653. In our view, it would be prudent for complainants to be consulted about the terms of inquiry directions and the matters to be inquired into before those directions are issued, especially when a complaint is complex or involves several issues.

Length of inquiries

654. To conduct an inquiry typically takes time. In September 2023, the Director said that in the previous year, the average time taken was 352 days.⁴⁹³ We understand this to be from the start of the inquiry, and not from the date when the complaint was received.

655. We have seen inquiry reports where longer periods of time were involved.⁴⁹⁴

656. The DII Handbook does not prescribe timeframes for the completion of inquiries.

657. The Inspector-General told us that the time taken to complete an inquiry can be influenced by many factors, including:

- the complexity of the complaint
- how much time has elapsed since the alleged incident
- the number and location of personnel involved (complainants, respondents and witnesses)
- how many witness statements and pieces of evidence there are, and how easy it is to obtain them
- whether there is involvement of other functional areas
- the number of inquiries subject to review and clearance in the Office of the IGADF at a particular time.⁴⁹⁵

658. Another factor is the availability of Assistant Inspectors-General to conduct inquiries. The Director said that:

in the 2022 calendar year ... [w]e had periods of time where we had up to 20 matters that had not yet been allocated to an Assistant IGADF because we didn't have one to allocate it to.⁴⁹⁶

659. The Director added that in previous years, there had been other factors involved, including delays in quality assurance and editorial work in the Office of the IGADF that required changes in delegations to allow matters 'to run more smoothly through the office'.⁴⁹⁷

660. Directions formulated for an inquiry include a 'Due Date' that is determined by the relevant Assistant Inspector-General; however, these dates are often not met. As the Director told us:

The challenge we have is that nearly all of our Assistant IGADFs underestimate [how much time] it takes, particularly to write a report once you have interviewed quite a number of witnesses so we do have a number of matters that have extensions and this is a challenge with timeliness.⁴⁹⁸

661. The IGADF Strategic Plan 2020–2022 contained a KPI (K7) that: '[i]nquiry reports (not including ADF deaths) are signed within a median of 6 months from the date of a signed direction';⁴⁹⁹ however, there is no such KPI or goal in the IGADF Strategic Plan 2023–2025.⁵⁰⁰
662. The Director said that, because of the wide variation in the nature and complexity of complaints or submissions, the DII was not able to formulate sensible KPIs for overall inquiry timeframes,⁵⁰¹ and that:
- the challenge that I had was because of the range of matters that we have, you know, a complaint about a fact-finding with poor procedural fairness that just lets me look at a document and review it, is quite different from 100 complaints with 96 witnesses.⁵⁰²
663. Past attempts to develop a 'complexity matrix' to consider the variables affecting timelines had been unsuccessful.⁵⁰³
664. While we accept that inquiries may vary significantly in terms of complexity and issues raised, there should be indicative timeframes. As with DSIR reports, a measure should be established against which the conduct of inquiries can be assessed and performance in relation to timeliness evaluated.
665. In our view, the aim should be that inquiries are completed and reports produced within an indicative period of 12 months from the date on which a relevant complaint is made. The exception would be for cases where any critical comments or findings about individuals mean that a procedural fairness process must be gone through. In those circumstances, an indicative timeframe of 15 months might apply.
666. These timeframes include the assessment phase, noting that an inquiry will have had the benefit of work done in that phase.

Communications

667. We have already discussed the importance of updating complainants during inquiries.
668. According to the DII Handbook, complainants are to be updated on the progress of the inquiry on a monthly basis.⁵⁰⁴ The Director told us that if complainants are not provided with monthly updates, that would not be in accordance with the procedure in the Office of the IGADF.⁵⁰⁵
669. Any occasional lapses in this regard should be avoided.
670. The DII Handbook makes no provision for updates to be provided to respondents or witnesses in inquiries and indeed, they are not routinely provided.

671. Inquiries can be very stressful, not only for the complainant, but for others involved in the circumstances of the complaint as well. We heard evidence from one witness who was interviewed as part of an inquiry and despite being told that regular updates would be provided to all involved, after some initial monthly emails, communication from the DII ceased.⁵⁰⁶
672. In our view, it would be preferable if monthly updates are given to respondents and witnesses after initial engagement with them, as they may also suffer from stress and anxiety related to the inquiry, unless there are compelling reasons in a particular instance that justify updates not being provided.

Legal and other supports

673. The Inspector-General does not provide legal assistance or other welfare support to people involved in an inquiry. This is said to ensure impartiality and avoid conflicts of interest. The Inspector-General considers that to provide such assistance would be inconsistent with its role as an independent inquiry body.⁵⁰⁷
674. In relation to legal support, people can access assistance at Commonwealth expense through Defence Counsel Services. The Inspector-General noted:

When appropriate during an Inquiry, the IGADF tries to ensure the availability of legal assistance at Commonwealth expense to any potentially affected persons. This includes not only ADF members and other Defence employees but also former ADF members and civilians. Potentially affected persons are afforded an opportunity to choose their own legal adviser from a reasonable selection of options.⁵⁰⁸

675. As for mental health care and wellbeing support, the Inspector-General sees its role as informing members about where to seek it, and to liaise with the chain of command about it. The Inspector-General says that welfare support for current ADF members is ordinarily provided by the chain of command.⁵⁰⁹
676. Legal and wellbeing supports for members engaged in inquiries is vital for their wellbeing. The responsibility for these supports, which are outlined in Chapter 10, The ADF military justice system, rests with Defence.

Accessing redacted and unredacted copies of reports

677. The DII Handbook refers to the fact that it is becoming almost routine for the Inspector-General to authorise certain people to read unredacted copies of inquiry reports and any supporting review reports – usually clinical reviews. Authorised people include complainants, respondents and, for deceased individuals or those suffering significant mental health issues, family members. Such access is said to be provided in order to avoid the necessity of drafting a highly complicated outcome letter.⁵¹⁰

678. Complainants and others are not given copies of unredacted reports. Rather, they are made available to be read under supervision.⁵¹¹ A witness told us of the discomfort this supervision caused her, and said she felt pressured to read the report quickly.⁵¹² In our view, it would be preferable if access were provided in a way that avoids such discomfort.

679. Another aspect of allowing certain people to read an unredacted copy of the inquiry report is the making of non-disclosure directions pursuant to section 21 of the IGADF Regulation. We have discussed these directions in the context of DSIR reports in section 12.3.8.

680. According to the Director, non-disclosure directions are used as sparingly as possible in relation to DII reports. She said:

The purpose of a section 21 order afterwards usually relates to individuals who have read the unredacted report and are, therefore, aware of material which they would not have known about otherwise, the evidence of other witnesses or the content of documents that they would not have had access to had they not read the report and we do not want that information shared. So that's the purpose of those orders.⁵¹³

681. As to what section 21 non-disclosure directions entail, the Director said:

So, the – the order specifically says that they may discuss the inquiry report with a legal practitioner, with a counsellor, psychologist or another professional who has confidentiality requirements, and if the individual tells us that they would like to discuss it with family members, we just issue ... we can issue the section 21 order, including their family, which allows them to then discuss the matter with their family as well. It is also the case ... that a section 21 order after an inquiry does not prevent an individual from talking about anything that is in their personal experience that they already knew before they were involved in one of our inquiry processes. So, they are completely free to tell their ... story to whoever they would like. What they can't do is use the confidential information they know about solely because of the inquiry, whether that be the evidence of other witnesses or the contents of documents. That is the only material to which the section 21 applies, so it does not prevent them from talking about their experience ... with other people. It's very narrowly focused.⁵¹⁴

682. The Director added:

We also prepare redacted copies of inquiry reports and that goes to the issue of assisting individuals to know which are the areas of the report that the office is not comfortable about being spoken about more widely. So, if I can give the example again of the debriefing that I did last week, the individuals read the unredacted report and then at the end of the meeting, they went away with the redacted copy so that they had a copy with them that they were free to discuss with – with other individuals ... Some time ago they had to specifically request [a redacted copy]. We've now realised that it is much easier if we just prepare it all at the same time, so our administrative staff proactively ask.⁵¹⁵

683. From our understanding of the evidence, the way in which non-disclosure directions are made and operate with respect to unredacted DII reports differs from the way they are made in relation to reports concerning the death of ADF members. Some of the concerns we raised in relation to section 21 directions made in the DSIR do not appear to arise – for example, the application of a direction to information already known to a person. To the extent that the reforms we propose in relation to the DSIR are not already addressed by the practice in the DII, however, they should apply to section 21 directions made in the context of unredacted DII inquiry reports.
684. One of the reforms is that it should always be fully explained that a consequence of reading the unredacted report is that non-disclosure directions will be made, and what the full effect of these directions are.
685. The Director of the DII said it had not occurred to her that this should occur.⁵¹⁶
686. We have been told that since Hearing Block 11, steps have been taken to update the DII Handbook to specify that people must be made aware of any relevant section 21 directions at the time they are given an opportunity to read an unredacted inquiry report.⁵¹⁷
687. We have also heard about concerns regarding the redaction of DII inquiry reports that are provided to complainants, which are sometimes heavily redacted pursuant to section 27(7) of the IGADF Regulation.
688. We heard evidence from one witness that a lot of the wording of the report she had been provided was redacted, so that it was ‘really hard to work out what ... were the recommendations, what were all the findings, what – you know, what were the details’.⁵¹⁸
689. We would encourage the Inspector-General to keep redactions to a minimum, having regard to the specific reasons for redactions specified in section 27(7) of the IGADF Regulation.

Implementation of recommendations

690. Reports of inquiries concerning complaints about failures of military justice can contain many recommendations by the Inspector-General.
691. After an Inspector-General’s inquiry report is given to the CDF, ADFHQ manages the process of implementing recommendations. The DII Handbook documents no process by which the Inspector-General monitors the implementation of recommendations in inquiry reports or assessment reports.

692. The Director told us during Hearing Block 11 that up until about 12 or 18 months previously, there was no tracking of recommendations, on the basis that the Inspector-General could not enforce them. Since then, however, she said that the DII has been asking Defence how recommendations and findings in DII inquiry reports had been implemented.⁵¹⁹ She noted that recommendations may not be implemented following the exact wording of the report, and said that where recommendations are not implemented, the DII asks Defence to explain why not.⁵²⁰
693. She recognised, however, that a weakness in the system is that the Inspector-General has no way of checking when Defence tells the DII that a recommendation has been implemented.⁵²¹
694. We have been told that since Hearing Block 11, where the Inspector-General recommends that a service act on a particular complaint, the Inspector-General specifically asks for updates from the service. The Inspector-General's correspondence to the complainant with regards to the outcome of the inquiry also encourages them to inform the Inspector-General if a recommendation has not been 'effected'.⁵²²
695. While these various actions may enable the Inspector-General to monitor recommendations and their implementation to some degree, in our view the processes in place are insufficient. We think there should be a formalised process by which the Inspector-General is advised on all actions taken by Defence in relation to the implementation of recommendations in inquiry reports. This will enhance the Inspector-General's oversight function.

12.6.6 The post-inquiry cell

696. Related to the subject of monitoring recommendations, the Director of the DII told us that a new cell is being developed in the Office of the IGADF with the working name 'post-inquiry cell'. The cell will do various things, including tracking the implementation of recommendations in DII inquiry reports. The Director said:

[W]e are having a cell that's being developed at the moment. The first few positions have been recruited and they're setting up their [standard operating procedures] at present. But they'll be responsible for ... post-inquiry matters across the entire office, not just my directorate, which I understand will include three areas. It will include engagement with complainants after the event to receive their feedback so that we can do more quality assurance and improvement in the way we conduct our processes. They will also be looking at tracking our findings and recommendations to the department and chasing those up, which is something we haven't had the capacity to do. And then they can also do that analysis function to be able to work out across the office and across the directorates what are the issues we need to look at, not on a case-by-case basis but on a more strategic level.⁵²³

697. The Director said the reasons for the establishment of the new cell go back to a decision in the IGADF Strategic Plan 2020–2022 that more assurance and feedback was needed in order for the Office of the IGADF to improve. The Director also referred to the Complainant Feedback Survey:

[I]t tracks back to a decision that was made, not in the current strategic plan but the previous strategic plan, that we needed to do more – more assurance and that we needed to get more feedback to be able to improve. That led to a really small sample study called the ‘CSBA [Complainant Feedback Survey] study’, which I am aware has also been tendered [to the Royal Commission]. And then, as a result of that, the most recent strategic plan has expanded to look much more at these areas where we’re not moving beyond the individual cases, to allow us to track recommendations and findings, to seek feedback from internal improvement and to look more strategically.⁵²⁴

698. It is apparent from the evidence that the new cell will focus not only on inquiries conducted by the DII, but will be concerned with work across the Office of the IGADF more generally. The Director confirmed that the functions of the cell will extend beyond engaging with complainants about the adequacy of or deficiencies in processes, to undertaking a systemic analysis of issues that arise in assessments and inquiries across the DII, DMRR and DSIR.⁵²⁵

699. The establishment of a cell within the Office of the IGADF of the kind and with the functions outlined here would plainly be of great benefit. It is an initiative we endorse and encourage.

700. Since the Director gave her evidence, we have been informed that the new cell is to be titled the ‘Post-IGADF Liaison Officer Team’, and is scheduled to commence work in the first quarter of 2024.⁵²⁶

12.6.7 Own-initiative inquiries

701. As already noted, the Inspector-General has the power to conduct an inquiry into matters concerning the military justice system on their own initiative.⁵²⁷

702. Since 1 January 2017, the Inspector-General has conducted five own-initiative inquiries. The completed inquiries are:

- 01/17: Own-initiative inquiry into Service Police Professional Standards
- 01/20: Own-initiative inquiry into the Publication of Courts Martial and Defence Force Magistrate Trials
- 02/20: Own-initiative inquiry into the ADF’s Prohibited Substance Testing Program
- 01/21: Own-initiative inquiry into Defence’s Arrangements for Dealing with Sexual Misconduct in the ADF.⁵²⁸

703. A further own-initiative inquiry – 01/22: Own-initiative inquiry into Military Justice Instruments – was established on 14 September 2022 and was ongoing at 19 July 2023.⁵²⁹
704. Given the issues we have heard about in relation to the military justice system, it is surprising that the Inspector-General has only used their power to conduct own-initiative inquiries to this extent.
705. As discussed in Chapter 10, The ADF military justice system, issues for consideration may include the weaponisation of the system against members, or issues with Defence administrative inquiries.⁵³⁰
706. The Director of the DII gave evidence that she had identified from Inspector-General inquiry reports a number of recurring issues with the conduct of administrative inquiries in Defence. She told us that:
- over the course of a number of inquiries, I had become quite concerned that there were some gross errors in a number of departmental inquiries that, in my view, should have been picked up by the legal officers that were conducting the reviews – the legal reviews of those reports prior to their finalisation, and I was very concerned that they had not been.⁵³¹
707. The issues the Director identified included:
- ‘findings not supported by evidence’
 - ‘insufficient analysis of credibility and reliability of witnesses’
 - ‘incorrect characterisation of complaints’
 - ‘manifest unfairness in outcomes’
 - ‘leading questions’
 - ‘lack of procedural fairness’
 - ‘findings out of scope’.⁵³²
708. While the Director raised these issues with the Military Justice Legal Forum (as discussed further in Chapter 10), they have not been made the subject of an own-initiative inquiry by the Inspector-General.
709. Inadequate resourcing may be the reason why so few own-initiative inquiries are conducted.

710. The Director told us:

A. ... I would say that due to the current workload we do a lot less analysis of what matters might be suitable for own-motion investigation than would be ideal.

Q. And do you think that desirable, in terms of IGADF performing its function of investigating an inquiry into the military justice system?

A. I think it's absolutely desirable to do more analysis and more work, yes.

Q. And in terms of the barriers, is resourcing the principal barrier?

A. Yes, absolutely.⁵³³

711. Resourcing must be addressed to enable the Inspector-General to conduct more own-initiative inquiries into matters concerning military justice failings.

712. In relation to administrative inquiries in Defence, Mr Gaynor told us that while there were issues of which he was aware, 'it would be wrong to say that they are universal problems in every Defence inquiry'. He said he did not regard them as 'necessarily systemic' because they 'do not arise in every inquiry that we review as part of the work of my office' and he would not 'describe any of the issues as being issues that [he] regard[s] as so widespread as to indicate a systemic problem'.

713. We do not express a view about this assessment by the Inspector-General, but we do suggest that the Inspector-General might lower the threshold at which an own-initiative inquiry is considered warranted.

12.7 Recommendations

714. To address various issues in relation to the Inspector-General and the Office of the IGADF discussed in this chapter, we make the following recommendations:

Recommendation 42: Ensure that future Inspectors-General of the Australian Defence Force will not have served in the ADF

The Australian Government should amend Part VIIIB Division 2, sections 110E to 110P of the *Defence Act 1903* so that:

- (a) a person appointed as the Inspector-General of the ADF must not have served in the ADF
- (b) the Inspector-General should be supported by two Deputy Inspectors-General with appropriate skills and experience, for example, having served in the ADF or having experience and understanding of the justice system, including military justice
- (c) the Deputy Inspector-General positions are to be statutory appointments.

Recommendation 43: Allow the Inspector-General of the Australian Defence Force to make recruitment decisions for the staffing of their office

The Inspector-General of the Australian Defence Force (ADF) should have the responsibility and authority for the selection of staff in their office, including as to whether staff are drawn from the ADF, the Australian Public Service, or from other sources.

The Inspector-General should have the power to select and recruit freely from the ADF without being constrained by whom the Chief of the Defence Force, the service chiefs or the Director of Military Legal Capability select or recommend.

Recommendation 44: Ensure that staff of the office of the Inspector-General of the Australian Defence Force have the necessary skills, expertise and qualifications

The Inspector-General of the Australian Defence Force (ADF) should develop a workforce plan that includes:

- (a) a review of the skills, expertise and professional qualifications required to discharge effectively the Inspector-General's complete functions
- (b) an assessment of the current workforce in the office of the Inspector-General of the ADF in which any competency gaps are identified
- (c) a strategic plan to attract and deliver the required capability profile to the office of the Inspector-General of the ADF.

Recommendation 45: Improve transparency and accountability of the Inspector-General of the Australian Defence Force by increasing their reporting requirements

The Inspector-General of the Australian Defence Force (ADF) should improve the transparency and accountability of their office by:

- (a) updating and publishing comprehensive guidance or other standard operating procedures on its website, including quality-assurance measures, related to the discharge of the Inspector-General's functions in each directorate of the office of the Inspector-General
- (b) establishing and including in this guidance specific performance measures related to timeliness in the completion of assessments and inquiries and the consideration of redress of grievance complaints, and reporting annually on performance against these measures.

Recommendation 46: Ensure staff of the Inspector-General of the Australian Defence Force are trained in trauma-informed practice

The Inspector-General of the Australian Defence Force (ADF) should ensure that all staff in the office of the Inspector-General (including consultants) who engage with members' next of kin and family members; are communicating with complainants, respondents or witnesses for the purpose of an inquiry; or who are charged with considering a redress-of-grievance complaint have completed the Compassionate Foundations course or equivalent training in trauma-informed practice before doing so, and do refresher training every two years.

Recommendation 47: The Inspector-General to inquire into all deaths of serving members unless suicide can be excluded as the cause of death

The Inspector-General of the Australian Defence Force (ADF) should ensure that where suicide cannot be categorically excluded as the cause of death of an ADF member, a formal inquiry under written directions is conducted.

When undertaking such an inquiry, the Inspector-General should obtain input from a qualified mental health expert, such as a psychologist, when determining:

- (a) whether suicide may have been the cause of death
- (b) where suicide cannot be excluded, what the contributing factors may have been and whether there was a 'service nexus'
- (c) what recommendations should be made.

Recommendation 48: When a member dies by suicide, appoint a legal officer to represent the interests of the deceased and support the next of kin

When a serving member dies by suicide, or is suspected to have died by suicide, the Inspector-General of the Australian Defence Force should ensure that a legal officer from Defence Counsel Services has been appointed to represent the interests of the deceased upon written directions for a formal inquiry being issued.

The Inspector-General should ensure that interviews with the member's next of kin are conducted after the legal officer has been appointed and made contact with them.

Recommendation 49: Minimise disclosure restrictions of Inspector-General inquiry reports and ensure they are fair and understood by the next of kin

In relation to non-disclosure directions made pursuant to section 21 of the *Inspector General of the Australian Defence Force Regulations 2016*:

- (a) staff from the office of the Inspector-General must explain the scope of the Directions to next of kin and family members before they are made
- (b) the directions should not apply to information which next-of-kin themselves provide to an Inquiry, and which next-of-kin may know independently of anything contained in a draft, unredacted or redacted report
- (c) next-of-kin should be consulted directly about the persons that are to be included in the carve-outs to the directions permitting disclosure, and persons nominated by the next-of-kin should be included unless there is a good reason not to include them
- (d) restrictions on disclosure in respect of unredacted and redacted final reports should only extend to those parts of the reports that need to have disclosure restricted in the interests of the defence of the Commonwealth, or for reasons of fairness to a person who the Inspector-General considers may be affected by the inquiry
- (e) the Inspector-General should establish a mechanism by which next-of-kin may have the directions that are made reviewed by a legal officer of the office of the Inspector-General who was not involved in the relevant inquiry or in the decision to make the directions. The Inspector-General must have regard to the issues or concerns raised by the legal officer
- (f) there should be comprehensive guidance in relation to the making and terms of Section 21 directions included in the updated comprehensive guidance on the Inspector-General's website.

Recommendation 50: Amend the scope of the Inspector-General's role to inquire into suicide deaths of former Australian Defence Force members

The Inspector-General should be required and empowered to inquire into the death of a former Australian Defence Force (ADF) member where the death may have been by suicide, and where:

- (a) the death occurs:
 - (i) after 30 September 2024; and
 - (ii) within two years of the former member ceasing to be an ADF member; and
- (b) the Inspector-General is notified or otherwise learns of the death within three months of the date of death.

Recommendation 51: The Inspector-General to regularly review inquiries into suicide deaths to determine common themes

The Inspector-General of the Australian Defence Force should conduct a review of all inquiries and reports into suicide or suspected suicide every three years to determine whether there are any common themes and contributing factors, and report the findings to the Chief of the Defence Force, the Minister for Defence and the Minister for Defence Personnel.

Recommendation 52: Conduct a merits review when a member's service is involuntarily terminated and they submit a redress of grievance complaint

When a member makes a redress-of-grievance complaint concerning a decision to terminate their service, the Inspector-General of the Australian Defence Force should:

- (a) (in addition to Recommendation 32) conduct a review in the nature of a merits review and determine, in their view, the correct or preferable decision
- (b) conclude their consideration of the complaint within 60 days of referral
- (c) give the member the opportunity to provide any further information or submissions prior to concluding their consideration of the complaint, in person, if practicable to do so, when the proposed outcome will not be favourable to the member.

Recommendation 53: Give members 21 days to make a complaint after being notified of a decision to terminate their service

Defence should amend Section 41(2) of the *Defence Regulations 2016* to allow a member to make a complaint up to 21 days after they are notified of a decision to terminate their service.

Recommendation 54: Improve the frequency of military justice-related audits conducted by the Inspector-General of the Australian Defence Force

The Inspector-General of the Australian Defence Force (ADF) should:

- (a) conduct a routine military justice performance audit of every major ADF unit every three years, and of every *ab initio* training establishment every two years
- (b) conduct a bi-annual longitudinal study of all audit reports every two years to determine trends, themes, and issues of concern, and provide the outcomes of this analysis to the Chief of the Defence Force, the Minister for Defence and the Minister for Defence Personnel.
- (c) audit at least three non-major units each year that are not part of the Directorate of Military Justice Performance Audit routine audit cycle.

Endnotes

- 1 Inspector-General of the Australian Defence Force, 'What We Do', webpage, www.igadf.gov.au/what-we-do, viewed 14 June 2024 (Exhibit QQ-01.001, DVS.6666.0001.5793); Exhibit 79-02.001, Hearing Block 11, Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-002, Background Paper, IGD.9999.0002.0003 at 0007 [2.10].
- 2 Exhibit BB-01.016, Terms of Reference, Review of the Office of the Inspector-General of the Australian Defence Force, dated 20 September 2023, DVS.6666.0001.3630 at 3630 [7].
- 3 Exhibit P-01.002, Twenty-Year Review of the Office of the Inspector-General of the Australian Defence Force, Report, IGD.0036.0001.0001.
- 4 JCS Burchett, *Report of an Inquiry into Military Justice in the Australian Defence Force*, July 2001, pp 28 [66], 39 [55] (Exhibit QQ-01.002, DVS.0011.0001.0325).
- 5 *Defence (Inquiry) Amendment Regulations 2003* (Cth); Exhibit 79-02.001, Hearing Block 11, Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-002, Background Paper, IGD.9999.0002.0003 at 0008 [2.11].
- 6 *Defence Legislation Amendment Act (No. 2) 2005* (Cth).
- 7 *Defence Legislation Amendment Act (No. 2) 2005* (Cth) s 2; *Defence Act 1903* (Cth) s 110E.
- 8 *Defence Legislation Amendment Act (No. 2) 2005* (Cth) s 2; Exhibit 79-02.001, Hearing Block 11, Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-002, Background Paper, IGD.9999.0002.0003 at 0010 [2.15].
- 9 *Defence Legislation Amendment Act (No 2) 2005* (Cth) s 110D.
- 10 *IGADF Regulation 2016* (Cth) s 5(a)–(d); *Defence Regulation 2016* (Cth) s 43–47; Exhibit 79-02.002, Hearing Block 11, Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-002, Response to Questions 1–4, IGD.9999.0002.0730 at 0731 [1.4].
- 11 *Defence Act 1903* (Cth) s 110C(1)(e), 110DA.
- 12 Exhibit 79-02.002, Hearing Block 11, Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-002, Response to Questions 1–4, IGD.9999.0002.0730 at 0731 [1.4].
- 13 *Defence Act 1903* (Cth) s 110G.
- 14 Exhibit 79-02.001, Hearing Block 11, Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-002, Background Paper, IGD.9999.0002.0003 at 0011 [2.16].
- 15 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, p 84-8317 [6–29].
- 16 Exhibit 79-02.001, Hearing Block 11, Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-002, Background Paper, IGD.9999.0002.0003 at 0026 [3.6]–0027 [4.1].
- 17 *Defence Act 1903* (Cth) s 110O; Exhibit 79-03.001A, Hearing Block 11, Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-002, Response to Questions 8–11, IGD.9999.0001.0001 at 0002 [8.5].
- 18 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, p 84-8330 [5–9]; Exhibit 79-02.00, Hearing Block 11, Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-002, Background Paper, IGD.9999.0002.0003 at 0013 [2.23].
- 19 Exhibit 79-02.00, Hearing Block 11, Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-002, Background Paper, IGD.9999.0002.0003 at 0026 [3.6]; Transcript, Catherine Wallis, Hearing Block 11, 5 September 2023, p 82-8003 [21–23].
- 20 Exhibit , Hearing Block 11, Noting Brief for CDF: IGADF June 2023 Update, IGD.0016.0001.0001 at 0002 [3]; Transcript, Damian Spendelove, Hearing Block 11, 31 August 2023, p 79-7669 [4-15].
- 21 Exhibit 79-02.005, Hearing Block 11, Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-009, IGD.9999.0005.0001 at 0008 [9]; Transcript, James Gaynor, Hearing Block 11, 7 September 2023, p 84-8331 [14–17].
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- 23 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, pp 84-8329 [40]–84-8330 [12].
- 24 *Defence Act 1903* (Cth) s 110O(2).

- 25 Exhibit 79-02.001, Hearing Block 11, Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-002, Background Paper, IGD.9999.0002.0003 at 0024–0025 [3.3].
- 26 Transcript, James Gaynor, Hearing Block 11, 8 September 2023, pp 85-8357 [31]–85-8358 [25].
- 27 PFL-5 (IGADF Tranche 2 (ROG), Commonwealth Response), PFL.0008.0002.0032 at 0035.
- 28 Transcript, Catherine Wallis, Hearing Block 11, 5 September 2023, p 82-8014 [30–38].
- 29 *Defence Act 1903* (Cth) s 110P.
- 30 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, p 84-8315 [6–8].
- 31 Exhibit 82-01.002, Hearing Block 11, Mona Shindy, Witness Statement, MSH.0000.0001.0001_R at 0005 [26–30].
- 32 Exhibit 77-02.001, Hearing Block 11, Nikki Coleman, Witness Statement, NCA.0000.0001.0001_R at 0037 [149–152]; Transcript, Nikki Coleman, Hearing Block 11, 29 August 2023, p 77-7463 [20–21].
- 33 Transcript, Nikki Coleman, Hearing Block 11, 29 August 2023, p 77-7472 [1–2].
- 34 Transcript, MB1, Hearing Block 11, 1 September 2023, pp 80-7795 [43]–80-7796 [12].
- 35 Transcript, MB1, Hearing Block 11, 1 September 2023, pp 80-7796 [42]–80-7797 [5].
- 36 Kay Danes, Submission, ANON-Z1E7-Q8YA-A; Name withheld, Submission, ANON-Z1E7-QENE-G.
- 37 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, pp 84-8316 [42]–84-8317 [5].
- 38 Transcript, Catherine Wallis, Hearing Block 11, 5 September 2023, pp 82-8050 [39]–82-8051 [10].
- 39 Exhibit 82-02.008, Hearing Block 11, CSBA – Final Report – Complainant Feedback Survey, August 2021, IGD.0007.0014.0001 at 0019.
- 40 Exhibit P-01.002, Twenty-Year Review of the Office of the Inspector-General of the Australian Defence Force, Report, IGD.0036.0001.0001 at 0023 [53].
- 41 *Defence Act 1903* (Cth) s 110A.
- 42 *Defence Act 1903* (Cth) s 110A.
- 43 Exhibit 79-02.001, Hearing Block 11, Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-002, Background Paper, IGD.9999.0002.0003 at 0010 [2.15]–0012 [2.19].
- 44 Exhibit 79-02.001, Hearing Block 11, Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-002, Background Paper, IGD.9999.0002.0003 at 0012 [2.22].
- 45 Exhibit 79-02.001, Hearing Block 11, Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-002, Background Paper, IGD.9999.0002.0003 at 0013 [2.23].
- 46 *Defence Act 1903* (Cth) s 110R.
- 47 *Defence Act 1903* (Cth) s 110DB.
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- 49 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, p 84-8328 [25–30].
- 50 Transcript, Catherine Wallis, Hearing Block 11, 5 September 2023, pp 82-8049 [35]–82-8050 [5].
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- 53 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, p 84-8333 [20–36].
- 54 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, p 84-8333 [26–47].
- 55 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, p 84-8333 [26–30].
- 56 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, p 84-8332 [5–38].
- 57 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, p 84-833 [1–6].
- 58 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, p 84-8328 [5–20].
- 59 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, p 84-8328 [5–20].
- 60 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, p 84-8328 [41–44].
- 61 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, p 84-8328 [44–48].

- 62 Exhibit 79-03.001A, Hearing Block 11, Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-002, Response to Questions 8–11, IGD.9999.0001.0001 at 0002 [8.6].
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- 64 Transcript, Catherine Wallis, Hearing Block 11, 5 September 2023, p 82-8061 [7–10].
- 65 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, p 84-8314 [15–27].
- 66 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, p 84-8314 [28].
- 67 Exhibit 84-03.062, Hearing Block 11, Noting Brief for CDF: IGADF April 2023 Update, IGD.0010.0001.0084 at 0085 [3].
- 68 Exhibit 79-02.015AD, Hearing Block 11, Noting Brief for CDF: IGADF May 2022 Update, IGD.0010.0001.0106 at 0106 [4].
- 69 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, p 84-8326 [14–19].
- 70 Exhibit 79-02.002, Hearing Block 11, Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-002, Response to Questions 1–4, IGD.9999.0002.0730 at 0761 [1.64].
- 71 Exhibit 84-01.002, Hearing Block 11, Military Justice Steering Group Business Rules, IGD.0007.0006.0094 at 0094 [1].
- 72 Transcript, James Gaynor, Hearing Block 11, 8 September 2023, p 85-8421 [21–23].
- 73 Exhibit 79-02.002, Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-002, Response to Questions 1–4, IGD.9999.0002.0730 at 0761 [1.64].
- 74 Exhibit 84-01.033, Hearing Block 11, Minutes of Military Justice Steering Group 02/2022, IGD.0007.0006.0131 at 0133 [10].
- 75 Exhibit 82-02.009E, Hearing Block 11, Military Justice Steering Group, Minutes of Meeting 03/3031 of the MJSG, IGD.0007.0006.0099 at 0102.
- 76 Exhibit 84-01.032, Hearing Block 11, Military Justice Steering Group, Minutes of Meeting 01/2022 of the MJSG, IGD.0007.0006.0121 at 0124 [11–13].
- 77 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, p 84-8321 [5–35].
- 78 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, pp 84-8320 [23–29], 84-8321 [3–4].
- 79 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, p 84-8319 [37–42].
- 80 *Defence Act 1903* (Cth) s 110F.
- 81 Exhibit 79-02.001, Hearing Block 11, Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-002, IGADF Background Paper, IGD.9999.0002.0003 at 0011 [2.16].
- 82 Exhibit 79-02.001, Hearing Block 11, Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-002, IGADF Background Paper, IGD.9999.0002.0003 at 0011 [2.16].
- 83 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, p 84-8310 [10–30].
- 84 Exhibit 84-03.073, Hearing Block 11, Biography of Mr Gaynor, IGD.0023.0001.0005.
- 85 *Defence Act 1903* (Cth) s 110(F).
- 86 JCS Burchett, *Report of an Inquiry into Military Justice in the Australian Defence Force*, Report, July 2001, pp 165–66 [275] (Exhibit QQ-01.002, DVS.0011.0001.0325).
- 87 Transcript, James Gaynor, Hearing Block 11, 8 September 2023, p 85-8393 [31–41].
- 88 Transcript, Mona Shindy, Hearing Block 11, 5 September 2023, pp 82-7999 [3]–82-8000 [6].
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- 90 JCS Burchett, *Report of an Inquiry into Military Justice in the Australian Defence Force*, Report, July 2001, p 166 [275] (Exhibit QQ-01.002, DVS.0011.0001.0325).
- 91 Exhibit 62-01.005, Hearing Block 10, VCDF to CPERS Handover/Takeover Pack – Military Justice Accountable Officer, October 2023, DEF.1162.0002.0059 at 0054.
- 92 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, pp 84-8331 [30]–84-8332 [38]; Exhibit 79-02.015C, Hearing Block 11, Noting Brief for CDF: IGADF July 2023 Update, IGD.0016.0001.0011 at 0012 [5].
- 93 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, p 84-8333 [10–20].
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- 95 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, p 84-8333 [15–20].
- 96 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, pp 84-8334 [40]–84-8335 [3].
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- 98 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, pp 84-8327 [45]–84-8328 [1].

99 PFL-7 (IGADF Tranche 4 (IGADF and the OIGADF), Commonwealth response) PFL.0008.0002.0204 at 0215.

100 Exhibit 86-03.019, Hearing Block 12, VCDF to CPERS Handover/Takeover Pack – Military Justice Accountable Officer, October 2023, DJO.1001.0002.0001 at 0054 [7].

101 Exhibit 84-03.062, Hearing Block 11, Noting Brief for CDF: IGADF April 2023 Update, IGD.0010.0001.0084 at 0085 [5].

102 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, p 84-8326 [30–33].

103 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, pp 84-8326 [47]–84-8327 [5].

104 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7725 [35–45].

105 Transcript, Catherine Wallis, Hearing Block 11, 5 September 2023, p 82-8011 [5–10].

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110 *IGADF Regulation 2016* (Cth) s 5(a).

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114 Exhibit 79-02.015C, Hearing Block 11, Noting Brief for CDF: IGADF July 2023 Update, IGD.0016.0001.0011 at 0013 [6].

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116 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, pp 84-8331 [19 – 45].

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124 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7677 [26–42].

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- 152 Transcript, James Gaynor, Hearing Block 11, 8 September 2023, p 85-8379 [6–10].
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179 Exhibit 79-02.001, Hearing Block 11, Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-002, Background Paper, IGD.9999.0002.0003 at 0025 [3.4]; Exhibit 79-03.001A, Hearing Block 11, Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-002, Response to Questions 8–11, IGD.9999.0001.0001 at 0004 [9.7]; Exhibit 79-02.004A, Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-015, IGD.9999.0012.0040 at 0040 [1.1], 0041 [1.5], 0042 [1.9].

180 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7711 [30–40].

181 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7713 [25–32]; Exhibit 79-02.018, Hearing Block 11, Directorate of Select Incident Review Guidance Manual for Standard Operating Practices, version 2, IGD.0007.0002.0001 at 0003 [9(a)].

182 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7677 [8–15].

183 Exhibit 79-02.004A, Hearing Block 11, Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-015, IGD.9999.0012.0040 at 0045 [3.10].

184 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7722 [3–25].

185 Transcript, James Gaynor, Hearing Block 11, 8 September 2023, p 85-8361 [3–25].

186 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7713 [42–43].

187 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7712 [4–6]; Transcript, James Gaynor, Hearing Block 11, 8 September 2023, pp 85-8363 [1]–85-8364 [41].

188 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7712 [20–34].

189 Exhibit 64-01.011, Hearing Block 9, Decision Brief for CDF titled ‘SSIM AC 22-04 (Tranche 1): Analysis of IGADF Death by Suicide Reports Released between Jun 16 and Jun 22’, DEF.1063.0001.0023 at 0037 [37].

190 Transcript, Anneliese Hilder, Hearing Block 9, 23 May 2023, p 64-6197 [26–36].

191 Transcript, Patricia Fernandez de Viana, Hearing Block 1, 10 December 2021, p 10.904 [8–10].

192 Exhibit 64-01.011, Hearing Block 9, Decision Brief for CDF titled ‘SSIM AC 22-04 (Tranche 1): Analysis of IGADF Death by Suicide Reports Released between Jun 16 and Jun 22’, DEF.1063.0001.0023 at 0031 [7–8].

193 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7728 [28–31]; Transcript, John Mackenzie, Hearing Block 11, 31 August 2023, p 79-7728 [26–40]; Exhibit 77-06.001, Hearing Block 11, MB2, Witness Statement, WIT.0000.0012.0001_R at 0003 [22]–0004 [26].

194 Transcript, John Mackenzie, Hearing Block 11, 31 August 2023, p 79-7728 [35–40].

195 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, pp 79-7728 [4]–79-7729 [1].

196 Exhibit 77-06.001, Hearing Block 11, MB2, Witness Statement, WIT.0000.0012.0001_R at 0003-0004; Transcript, MB2, Hearing Block 11, 29 August 2023, pp 77-7482 [19], 77-7484 [41–43].

197 Transcript, MB2, Hearing Block 11, 29 August 2021, p 77-7486 [30].

198 Exhibit 77-06.001, Hearing Block 11, MB2, Witness Statement, WIT.0000.0012.0001_R at 0003 [22].

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200 Transcript, MB2, Hearing Block 11, 29 August 2021, p 77-7486 [30–34].

201 Transcript, James Gaynor, Hearing Block 11, 8 September 2023, pp 85-8356 [35]–85-8357 [1].

202 Transcript, John Mackenzie, Hearing Block 11, 31 August 2023, p 79-7728 [29–40].

203 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7725 [29–32].

204 Exhibit 79-02.015AAA, Hearing Block 11, Noting Brief for CDF: IGADF June 2023 Update, IGD.0016.0001.0001.

205 Transcript, John Mackenzie, Hearing Block 11, 31 August 2023, p 79-7726 [36–45].

206 Exhibit 79-02.015C, Hearing Block 11, Noting Brief for CDF: IGADF July 2023 Update, IGD.0016.0001.0011 at [1].

207 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7725 [35–45].

208 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7726 [1–4].

209 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7726 [5–11].

210 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, p 84-8327 [18–20].

211 PFL-4 (IGADF Tranche 1 (DSIR), Commonwealth response), PFL.0008.0002.0001 at 0016–0017.

212 PFL-4 (IGADF Tranche 1 (DSIR) Commonwealth response), PFL.0008.0002.0001 at 0016.

213 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7727 [28–38].

214 Transcript, James Gaynor, Hearing Block 11, 8 September 2023, p 85-8365 [30–46].

215 Transcript, James Gaynor, Hearing Block 11, 8 September 2023, p 85-8366 [10–12].

216 Transcript, James Gaynor, Hearing Block 11, 8 September 2023, p 85-8366 [35–42].

217 Exhibit F-03.030, Inspector-General of the Australian Defence Force Strategic Plan 2023–2025, IGD.0027.0001.0224; Transcript, James Gaynor, Hearing Block 11, 8 September 2023, p 85-8366 [12].

218 Exhibit F-03.030, Inspector-General of the Australian Defence Force Strategic Plan 2023–2025, IGD.0027.0001.0224 at 0025.

219 Exhibit F-03.030, Inspector-General of the Australian Defence Force Strategic Plan 2023–2025, IGD.0027.0001.0224 at 0235.

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221 Transcript, James Gaynor, Hearing Block 11, 8 September 2023, p 85-8369 [3–15]; Transcript, James Gaynor, Hearing Block 11, 8 September 2023, p 85-8369 [18–21].

222 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7727 [44–45].

223 Exhibit 79-02.018, Hearing Block 11, Directorate of Select Incident Review Guidance Manual for Standard Operating Practices, version 2, 29 November 2022, IGD.0007.0002.0001 at 0010 [33].

224 Exhibit 79-02.018, Hearing Block 11, Directorate of Select Incident Review Guidance Manual for Standard Operating Practices, version 2, 29 November 2022, IGD.0007.0002.0001 at 0011 [38].

225 Exhibit 79-02.018, Hearing Block 11, Directorate of Select Incident Review Guidance Manual for Standard Operating Practices, version 2, 29 November 2022, IGD.0007.0002.0001 at 0011 [35].

226 Exhibit 79-02.002, Hearing Block 11, Office of the Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-002, Response to Questions 1–4, IGD.9999.0002.0730 at 0744 [1.42(b)].

227 Exhibit 79-02.002, Hearing Block 11, Office of the Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-002, Response to Questions 1–4, IGD.9999.0002.0730 at 0744 [1.42(c)].

228 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7708 [4–5].

229 PFL-4 (IGADF Tranche 1 (DSIR) Commonwealth response), PFL.0008.0002.0001 at 0020.

230 Transcript, MB2, Hearing Block 11, 29 August 2023, pp 77-7482 [19]–77-7483 [7]; Exhibit 90-01.009, Hearing Block 12, Kathryn Rae, Witness Statement, WIT.0011.0001.0111_R at 0111–0112 [8].

231 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-77083 [31].

232 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7708 [1–8].

- 233 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7710 [24–35].
- 234 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7710 [32].
- 235 Exhibit 79-02.018, Hearing Block 11, Directorate of Select Incident Review Guidance Manual for Standard Operating Practices, version 2, 29 November 2022, IGD.0007.0002.0001 at 0005 [9(g)], 0011 [38].
- 236 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7701 [36–43].
- 237 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7715 [6–7].
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- 239 Exhibit 79-02.004A, Hearing Block 11, Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-015 at IGD.9999.0012.0040 at 0045 [3.7].
- 240 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7715 [15–27].
- 241 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, pp 79-7714 [3]–79-7716 [25].
- 242 Exhibit QQ-01.004, Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-018, IGD.9999.0022.0001.
- 243 PFL-4 (IGADF Tranche 1 (DSIR), Commonwealth response), PFL.0008.0002.0001 at 0022.
- 244 Transcript, John Mackenzie, Hearing Block 11, 31 August 2023, p 79-7747 [39–45]; Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, 79-7748 [1–5].
- 245 Exhibit QQ-01.003, Joshua Clifford, Witness Statement, DEF.9999.0194.0001 at 0005 [8].
- 246 Exhibit 79-02.018, Hearing Block 11, Directorate of Select Incident Review Guidance Manual for Standard Operating Practices, version 2, 29 November 2022, IGD.0007.0002.0001 at 0011 [41].
- 247 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7708 [10–15].
- 248 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, pp 79-7682 [27–30], 79-7714 [44–47].
- 249 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, pp 79-7705 [29]–79-7706 [5]; Exhibit 77-06.001, Hearing Block 11, MB2, Witness Statement, WIT.0000.0012.0001_R at 0002 [13]; PFL-4 (IGADF Tranche 1 (DSIR), Commonwealth response), PFL.0008.0002.0001 at 0021.
- 250 Transcript, MB2, Hearing Block 11, 29 August 2023, p 77-7486 [17–20].
- 251 PFL-4 (IGADF Tranche 1 (DSIR), Commonwealth response), PFL.0008.0002.0001 at 0022.
- 252 Exhibit QQ-01.003, Joshua Clifford, Witness Statement, DEF.9999.0194.0001 at 0045 [123], [127], 0047 [136–137]; Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7682 [23–25]; Exhibit 79-02.018, Hearing Block 11, Directorate of Select Incident Review Guidance Manual for Standard Operating Practices, version 2, 29 November 2022, IGD.0007.0002.0001 at 0011 [41].
- 253 Exhibit QQ-01.003, Joshua Clifford, Witness Statement, DEF.9999.0194.0001 at 0045 [127]–0046 [128].
- 254 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7682 [25].
- 255 Transcript, MB2, Hearing Block 11, 29 August 2023, p 77-7485 [1–5].
- 256 Transcript, MB2, Hearing Block 11, 29 August 2023, pp 77-7485 [4]–77-7486 [5].
- 257 Exhibit 79-02.063, Hearing Block 11, Redacted, Witness Statement, WIT.0011.0001.0007 at 0009 [16–19].
- 258 Exhibit 90-01.009, Hearing Block 12, Kathryn Rae, Witness Statement, WIT.0011.0001.0111_R at 0115 [32].
- 259 Exhibit 77-06.001, Hearing Block 11, MB2, Witness Statement, WIT.0000.0012.0001_R at 0003 [18].
- 260 Transcript, Patricia and Michael Fernandez de Viana, 12 December 2021, pp 10-904 [42]–10-906 [5], 10-908 [14–19].
- 261 Transcript, James Gaynor, Hearing Block 11, 8 September 2023, p 85-8345 [30–35].
- 262 Transcript, James Gaynor, Hearing Block 11, 8 September 2023, p 85-8346 [4–20].
- 263 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7737 [24–27].
- 264 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, pp 79-7737 [38]–79-7738 [1].
- 265 Exhibit 90-01.009, Hearing Block 11, Kathryn Rae, Witness Statement, WIT.0011.0001.0111_R at 0115 [32]; Exhibit 77-06.001, Hearing Block 11, MB2, Witness Statement, WIT.0000.0012.0001_R at 0003 [18].
- 266 Transcript, James Gaynor, Hearing Block 11, 8 September 2023, p 85-8346 [20–26].

267 Exhibit 79-02.015AAA, Hearing Block 11, Noting Brief for CDF: IGADF June 2023 Update, IGD.0016.0001.0001 at 0004–0005.

268 Exhibit 79-02.018, Hearing Block 11, Directorate of Select Incident Review Guidance Manual for Standard Operating Practices, version 2, 29 November 2022, IGD.0007.0002.0001 at 0011 [39].

269 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7682 [10–35].

270 Transcript, Damien Spendelove, Hearing Block 11, 7 September 2023, p 79-7749 [26–28].

271 Exhibit 79-02.018, Hearing Block 11, Directorate of Select Incident Review Guidance Manual for Standard Operating Practices, version 2, 29 November 2022, IGD.0007.0002.0001 at 0012 [42].

272 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7741 [5–26]; Transcript, James Gaynor, Hearing Block 11, 8 September 2023, pp 85-8352 [25]–85-8354 [36].

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274 *IGADF Regulation 2016* (Cth) s 21.

275 *IGADF Regulation 2016* (Cth) s 27.

276 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7741 [38–39].

277 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7741 [44–46].

278 Transcript, James Gaynor, Hearing Block 11, 8 September 2023, p 85-8354 [38–42].

279 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7742 [8–12].

280 Transcript, James Gaynor, Hearing Block 11, 8 September 2023, p 85-8354 [10–36].

281 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, pp 79-7749 [34]–79-7750 [3].

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284 Exhibit 90-01.009, Hearing Block 11, Kathryn Rae, Witness Statement, WIT.0011.0001.0111_R at 0116 [39].

285 Transcript, John Mackenzie, Hearing Block 11, 31 August 2023, p 79-7750 [6–7].

286 Transcript, John Mackenzie, Hearing Block 11, 31 August 2023, p 79-7750 [5–15].

287 PFL-4 (IGADF Tranche 1 (DSIR), Commonwealth response), PFL.0008.0002.0001 at 0025.

288 Transcript, James Gaynor, Hearing Block 11, 8 September 2023, pp 85-8353 [33]–85-8353 [41].

289 PFL-4 (IGADF Tranche 1 (DSIR), Commonwealth response), PFL.0008.0002.0001 at 0024.

290 Transcript, James Gaynor, Hearing Block 11, 8 September 2023, p 85-8355 [7–10].

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294 PFL-4 (IGADF Tranche 1 (DSIR), Commonwealth response), PFL.0008.0002.0001 at 0022.

295 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, pp 85-8347 [14]–85-8348 [42].

296 Exhibit 79-02.015C, Hearing Block 11, Noting Brief for CDF: IGADF July 2023 Update, IGD.0016.0001.0011 at 0012 [6].

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298 Exhibit BB-01.017, Email, 4 August 2023, from [redacted] to [redacted], DEF.1277.0001.1291.

299 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, p 84-8338 [27–38].

300 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, p 84-8339 [2–5].

301 Transcript, James Gaynor, Hearing Block 11, 8 September 2023, p 85-8348 [21–27].

302 Transcript, James Gaynor, Hearing Block 11, 8 September 2023, p 85-8348 [35–38].

303 Transcript, Damien Spendelove, hearing Block 11, 31 August 2023, pp 79-7745 [38]–79-7746 [8].

304 Exhibit 79-02.018, Hearing Block 11, Directorate of Select Incident Review Guidance Manual for Standard Operating Practices, version 2, 29 November 2022, IGD.0007.0002.0001 at 0009 [28].

305 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, pp 85-8347 [14]–85-8348 [42].

306 Exhibit 79-02.015D, Hearing Block 9, IGADF Directive 02/2023 titled 'Interim Arrangements for the Management of Specified Office of the Inspector-General of the Australian Defence Force Functions and Roles', IGD.0018.0001.0001 at 0001 [3–4].

307 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, p 84-8339 [16–39].

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309 PFL-4 (IGADF Tranche 1 (DSIR), Commonwealth response), PFL.0008.0002.0001 at 0026.

310 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7699 [6–11].

311 Transcript, James Gaynor, Hearing Block 11, 8 September 2023, p 85-8381 [1–5].

312 Transcript, James Gaynor, Hearing Block 11, 8 September 2023, pp 85-8380 [39]–85-8381 [22].

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314 Exhibit 79-02.018, Hearing Block 11, Directorate of Select Incident Review Guidance Manual for Standard Operating Practices, version 2, 29 November 2022, IGD.0007.0002.0001 at 0004.

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316 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7700 [32–38].

317 Exhibit 79-02.018, Hearing Block 11, Directorate of Select Incident Review Guidance Manual for Standard Operating Practices, version 2, IGD.0007.0002.0001 at 0004; Exhibit 79-03.001A, Hearing Block 11, Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-002, IGD.9999.0001.0001 at 0005 [10.1].

318 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, p 79-7701 [1–20].

319 Transcript, Damien Spendelove, Hearing Block 11, 31 August 2023, pp 79-7742 [4]–79-7743 [3].

320 Transcript, James Gaynor, Hearing Block 11, 8 September 2023, p 85-8385 [10–13];
Transcript, James Gaynor, Hearing Block 11, 8 September 2023, p 85-8385 [1–13].

321 Transcript, James Gaynor, Hearing Block 11, 7 September 2023, p 84-8338 [1–16].

322 Exhibit 64-01.011, Hearing Block 9, Decision Brief for CDF titled 'SSIM AC 22-04 (Tranche 1): Analysis of IGADF Death by Suicide Reports Released between Jun 16 and Jun 22', DEF.1063.0001.0023 at 0034 [27].

323 Exhibit 92-02.013, Hearing Block 12, Noting Brief for CDF: Factors Involved in Service Suicides Over the Last Decade – Update, DEF.1289.0006.0003.

324 Transcript, Bernadette Boss, Hearing Block 1, 30 November 2021, pp 2-157 [5]–2-158 [1].

325 Transcript, James Gaynor, Hearing Block 11, 8 September 2023 p 85-8385 [24–42].

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329 Transcript, Richard Caton, Hearing Block 11, 7 September 2023, pp 84-8267 [30–46], 84-8272 [7–15].

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331 Transcript, James Gaynor, Hearing Block 11, 8 September 2023, p 85-8424 [16–27].

332 Transcript, Richard Caton, Hearing Block 11, 7 September 2023, p 84-8299 [5–10].

333 Transcript, James Gaynor, Hearing Block 11, 8 September 2023, p 85-8397 [5–7].

334 Transcript, James Gaynor, 7 September 2023, pp 84-8331 [19] - 84-8332 [37]

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337 PFL-4 (IGADF Tranche 1 (DSIR), Commonwealth response), PFL.0008.0002.0001 at 0004.

338 See *Millar v Bornholt* [2009] FCA 637 at [13]–[32] (Logan J).

339 *Millar v Bornholt* [2009] FCA 637 at [32] (Logan J).

340 Name withheld, Submission, ANON-ZQM6B-W.

341 *Defence Regulation 2016* (Cth) explanatory note [130]–[133].

342 Transcript, Andrew Snashall, Hearing Block 11, 1 September 2023, p 80-7817 [8].

343 *Defence Regulation 2016* (Cth) s 42.

344 *Defence Regulation 2016* (Cth) s 43(1).

345 *Defence Regulation 2016* (Cth) s 44.

346 Transcript, Andrew Snashall, Hearing Block 11, 1 September 2023, pp 80-7816 [1]–80-7818 [15].

347 Transcript, Andrew Snashall, Hearing Block 11, 1 September 2023, pp 80-7814 [28]–80-7817 [12].

348 Transcript, Andrew Snashall, Hearing Block 11, 1 September 2023, p 80-7823 [20–40].

349 Exhibit 80-01.001, Hearing Block 11, MB1, Witness Statement, WIT.0011.0001.0014 at 0040 [120].

350 *Defence Regulation 2016* (Cth) s 44(3).

351 *Defence Regulation 2016* (Cth) s 46.

352 *Defence Regulation 2016* (Cth) s 45(1).

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354 Exhibit 01-03.101, Hearing Block 1, Complaints and Alternative Resolutions Manual (CARM) Chapter 6, DEF.1096.0001.1060.

355 Exhibit 101-01.029, Hearing Block 12, Office of the IGADF Military Justice Statistics Catalogue FY2021–2022, DVS.0012.0001.2455 at 2477.

356 Transcript, Andrew Snashall, Hearing Block 11, 1 September 2023, p 80-7831 [25–33].

357 Name withheld, Submission, ANON-Z1E7-QQPP-9, supplementary material.

358 Name withheld, Submission, ANON-Z1E7-Q8BB-M.

359 Name withheld, Submission, ANON-Z1E7-QWCK-W.

360 Transcript, Andrew Snashall, Hearing Block 11, 1 September 2023, pp 80-7826 [40]–80-7827 [20].

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362 Transcript, MB1, Hearing Block 11, 1 September 2023, p 80-7796 [25–32].

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364 Transcript, Andrew Snashall, Hearing Block 11, 1 September 2023, p 80-7832 [29–33].

365 Transcript, Andrew Snashall, Hearing Block 11, 1 September 2023, pp 80-7853 [34–40], 80-7859 [40]–80-7860 [19].

366 Exhibit 80-02.002, Hearing Block 11, Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-006, Annexure A, IGD.9999.0003.0003.

367 Exhibit 80-02.002, Hearing Block 11, Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-006, Annexure A, IGD.9999.0003.0003; Exhibit 78-02.001, Hearing Block 11, Department of Defence, Response to Notice to Give, NTG-DEF-016, DEF.9999.0103.0123 at table 5.1.

368 Exhibit 80-02.002, Hearing Block 11, Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-006, Annexure A, IGD.9999.0003.0003.

369 Exhibit 80-02.002, Hearing Block 11, Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-006, Annexure A, IGD.9999.0003.0003.

370 Exhibit 80-02.002, Hearing Block 11, Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-006, Annexure A, IGD.9999.0003.0003; Transcript, Andrew Snashall, Hearing Block 11, 1 September 2023, p 80-7864 [18–30].

371 Exhibit 101-01.029, Hearing Block 12, Office of the IGADF Military Justice Statistics Catalogue FY2021–2022, DVS.0012.0001.2455 at 2477.

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373 Exhibit 80-02.002, Hearing Block 11, Inspector-General of the Australian Defence Force, Response to Notice to Give, NTG-IGD-006, Annexure A, IGD.9999.0003.0003; Transcript, Andrew Snashall, Hearing Block 11, 1 September 2023, pp 80-7839 [1–10], 80-7839 [25–35], 80-7844 [25–40].

374 Transcript, Andrew Snashall, Hearing Block 11, 1 September 2023, pp 80-7840 [10]–80-7842 [20].

375 Transcript, Andrew Snashall, Hearing Block 11, 1 September 2023, pp 80-7828 [39]–80-7829 [30].

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379 See, for example, Transcript, MB1, Hearing Block 11, 1 September 2023, 80-7796 [25–32];
Exhibit 80-02.003, Hearing Block 11, Letter from IGADF to [redacted] regarding Redress of
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13 Oversight of Defence workplace health and safety

Summary

This chapter outlines Defence's obligations under work health and safety (WHS) legislation and the state of internal and external mechanisms intended to protect the health and safety of Defence personnel.

As a duty holder under the *Work Health and Safety Act 2011* (Cth) (the WHS Act), Defence has a primary duty of care to ensure the physical and psychological health of Australian Defence Force (ADF) members. This includes identifying and managing psychosocial hazards and risks. Comcare, as the national regulator, oversees Defence's compliance with its duties under the WHS Act.

Internal WHS mechanisms aim to identify and limit exposure to hazards that give rise to risks, to reduce the likelihood of those risks being realised. This is material to our terms of reference as WHS mechanisms provide a direct opportunity to identify risks, intervene, and manage impacts on the health and wellbeing of Defence members.

Our examination of Defence's approach to WHS raises concerns about the efficacy of risk identification, and management and control mechanisms for suicide and suicidality. As discussed throughout this report, due to issues related to accurate and timely data collection, the ability of Defence to identify and respond to trends relating to suicide and suicidality is limited. As outlined in Chapter 11, Governance and accountability in Defence, limitations within the governance framework affect the capability of Defence to manage risks to the health and wellbeing of its workforce effectively.

Defence is required to inform Comcare of 'notifiable incidents' relating to the death or serious injury of workers that are related to their work. We have found that there is confusion across Defence about what incidents need to be notified, despite the promotion of an 'if in doubt, notify' approach. The legislative definition of a 'notifiable incident' is also very narrow. These two issues mean Defence may not notify Comcare of all incidents that relate to suicide and suicidality, limiting opportunities for the regulator to form a holistic view of psychosocial trends and hot spots.

We note resourcing limitations mean that Comcare focuses on its reactive functions – responding to incidents – rather than on proactively helping Defence to prevent injuries. We also found the WHS Act duty-holder requirement for Defence to do what is 'reasonably practicable' to eliminate or minimise psychosocial risks and hazards may mean it does not focus on what is best practice.

We acknowledge the work underway at Comcare to improve its understanding of psychosocial harm and its data analysis. We also acknowledge the steps that Defence is taking to improve systems.

However, this Royal Commission makes a series of recommendations to support Defence to do more to prevent psychosocial harm, and suicide and suicidality. These include actions to help it improve relevant WHS systems, improve data collection and analysis, and work with Comcare to gain more insights into trends. We are of the view that Defence can do much more to improve its prevention and early intervention strategies.

13.1 Introduction

1. Under the *Work Health and Safety Act 2011* (Cth) (WHS Act), Defence is accountable for the work health and safety (WHS) of its workers, including Australian Defence Force (ADF) members. It has a primary duty of care towards its workers that requires it to ensure their physical and psychological health and safety so far as is reasonably practicable.¹
2. The WHS Act applies to those at Australian Government departments and agencies, including Defence,² who have been designated as ‘a person who conducts a business or undertaking’. For Defence:

the Secretary, the CDF [Chief of the Defence Force], the Associate Secretary, Vice Chief of the Defence Force and all Group Heads and Service Chiefs have been designated a Person Conducting a Business or Undertaking under the legislation.³

3. Defence has a duty under the *Work Health and Safety Regulations 2011* (Cth) (WHS Regulations) to identify reasonably foreseeable hazards, including psychosocial hazards, that could give rise to health and safety risks. It must eliminate those risks so far as is reasonably practicable.⁴
4. However, as we set out in Chapter 1, Understanding suicide,⁵ the suicide rates for serving and ex-serving members have been high since the mid-2000s. Given Defence’s responsibility to manage psychosocial and other risks that can contribute to suicide and suicidality, we examine how Defence complies with the WHS Act and the role of the regulator Comcare.⁶
5. Our inquiry has identified opportunities for Defence to improve its approach to preventing and managing the psychosocial harm of its members. This chapter sets out Defence’s shortcomings in the governance of psychosocial risk and hazards, and notes that important information about psychosocial hazards could be improved to better support senior executive decision-making and intervention.
6. Risk identification, categorisation and controls do not always reflect the evidence. For example, Defence downplays the categorisation of psychosocial risk despite overwhelming data that such incidents are increasing in number.
7. To manage psychosocial hazards effectively, Defence must recognise the various drivers of psychosocial risk. As highlighted in Chapter 11, Governance and accountability in Defence, the recent recognition that service is not always protective, and may in some instances cause harm to Defence personnel, requires greater nuance in the management of organisational and in-service stressors.

8. We also found data limitations that prevent Defence and Comcare from fully understanding the root cause of psychosocial incident trends. A lack of clarity within Defence about when incidents of psychosocial harm involving ADF members should be reported to Comcare (which are defined as 'notifiable incidents' under the WHS Act) has likely resulted in under reporting.⁷
9. If Defence improved its data analysis of both notifiable and non-notifiable incidents, and shared the results of its analysis with Comcare, it would provide a clearer picture of any psychosocial trends and hot spots, enhancing Comcare's regulatory role. We also find that Comcare's and Defence's engagement with prevention and early intervention strategies could be improved.
10. In Chapter 11 we examined the limitations in processes and culture that have negatively impacted Defence's ability to reduce suicide and suicidality among serving and ex-serving members. In this chapter, we outline how similar limitations in the Defence WHS framework have also impacted Defence's ability to reduce psychosocial harm.
11. Before we consider how both Comcare and Defence can improve their role in preventing psychosocial harm, we provide an overview of the roles of Comcare and Defence in the WHS framework.

13.1.1 The role of Comcare

12. The WHS Act sets out the national health and safety framework for workers and workplaces, and Comcare is the regulator.⁸
13. Comcare was established under the *Safety, Rehabilitation and Compensation Act 1988* (Cth). It monitors and enforces compliance by persons conducting a business or undertaking who owe health and safety duties to their workers under the WHS Act.⁹ Approximately 20% of Comcare's regulatory business is Defence-related work.¹⁰
14. We use the term 'duty holders' to refer to persons conducting a business or undertaking. For the purposes of this chapter, Defence is a duty holder, as are the people in the designated roles mentioned in the section above.

Monitoring and enforcing compliance

15. Comcare has powers to monitor and enforce Defence's compliance with its WHS Act duties and obligations. The powers include holding audits, unannounced site visits and inspections. Comcare can also issue improvement notices and prohibition notices, and engage in enforcement activities such as conducting formal investigations.¹¹ Defence has the primary responsibility (and the primary duty) for ensuring it complies.¹²

16. Comcare operates within a model of 'responsive regulation' with escalating sanctions. The most serious sanction – prosecution – is used as a measure of last resort.¹³ Then Comcare CEO Ms Susan Weston PSM described this model as follows:

So, as a regulator we undertake a number of tasks. In the regulatory pyramid, you have some enforcement action at the top; so, we have serious investigations happening up there, and the body of the framework is inspection work or WHS audits or ... [the use of] improvement notices, prohibition notices – education perhaps is in that space. That's the bulk of where our work is, and inspection might be going proactively or reactively to look at what is happening in a workplace. And of course down the bottom is the education – the important education piece for a regulator.¹⁴

17. Ms Weston said Comcare issues an improvement or prohibition notice to Defence when it holds a reasonable belief that it has breached the WHS Act.¹⁵ Comcare may escalate to a formal investigation through a referral to the Commonwealth Director of Public Prosecutions. Breaches may include Defence non-compliance with its duty to report certain WHS incidents to Comcare and its duty to effectively manage psychosocial hazards and risks.
18. Comcare reserves the use of its formal investigation and prosecution powers for breaches that could warrant judicial proceedings.¹⁶
19. According to Ms Weston:

our investigation is operating on the basis that it may ... move to prosecution, and so the collection of evidence and information is with a view to that in mind ... But similarly, it may also be de-escalated to an inspection where ... the issues could be dealt with through some of the other enforcement powers we have.¹⁷

Providing information and advice

20. Comcare's education role includes providing duty holders with WHS information and advice, training, and conducting 'other proactive, preventative and consultative activities'.¹⁸ These activities may address a particular hazard or injury type and are based on Comcare's analysis of information, intelligence and data, and the needs of the jurisdiction.¹⁹
21. Comcare describes its information and advice role as the core activity for achieving a jurisdiction that is well informed, engaged, equipped to comply and committed to best practice.²⁰ Comcare explains that:

[a]s we progress towards our vision ... the balance of our activities will shift towards the more proactive and enabling measures. Over time, our need to call on sanctions and compulsive tools should be reduced.²¹

22. Examples of information and advice produced by Comcare include a regulatory guide on managing psychosocial hazards, as well as an education program to educate officers about their WHS duties and due diligence obligations.²² However, these educative tools were developed to assist all duty holders regulated by Comcare.²³ Programs that are tailored to Defence require additional funding from Defence (see section 13.4.4).

Notifiable incidents

23. As a WHS Act duty holder, Defence has a primary duty of care for the physical and psychological health and safety of ADF members and Defence Australian Public Service employees.²⁴ Defence must report all 'notifiable incidents' to Comcare; that is, all fatalities, 'serious injury or illness', and 'dangerous incidents' arising out of the conduct of the business or undertaking.²⁵
24. The WHS Act sets the parameters for these events and provides the definitions or criteria for what constitutes such an event.²⁶ Under the criteria, Defence needs to notify Comcare of only a small proportion of injuries that occur to ADF members.
25. Unlike other Commonwealth entities, the ADF is exempt from some provisions of the WHS Act, which are outlined in a written instrument by the Chief of the Defence Force.²⁷ These exemptions include the reporting of 'notifiable incidents' in warlike and non-warlike deployments, the consulting of workers, having health and safety representatives and committees, and the right to cease unsafe work.²⁸ These reflect the nature of Defence's work. However, they do not minimise Defence's responsibility to eliminate or minimise the risk of injury or harm to its personnel.

13.1.2 Defence as a duty holder

26. Defence has an obligation to identify and attempt to eliminate hazards and risks before they lead to an incident.
27. The WHS Regulations set out a duty holder's roles and responsibilities. Regulation 34 states:

a duty holder, in managing risks to health and safety, must identify reasonably foreseeable hazards that could give rise to risks to health and safety.²⁹

28. Regulation 35 states:

Risks to health and safety must be eliminated so far as is reasonably practicable. If it is not reasonably practicable to eliminate risks to health and safety, then the risks must be minimised so far as is reasonably practicable.³⁰

29. As a duty holder, Defence must implement control measures to manage psychosocial risks.³¹ This means that Defence must:
- identify reasonably foreseeable psychosocial hazards that could give rise to such risks³²
 - eliminate those risks so far as is reasonably practicable, or if not reasonably practicable, minimise those risks so far as reasonably practicable.³³
30. Table 13.1 provides the relevant definitions.

Table 13.1 Relevant WHS Act definitions

Term	Definition
Psychosocial hazard	<p>A psychosocial hazard may arise from or relate to:</p> <ul style="list-style-type: none"> • the design or management of work • a work environment • plant at a workplace • workplace interactions or behaviours. <p>Such a hazard may cause psychological harm (whether or not it may also cause physical harm).³⁴</p>
Psychosocial risk	<p>A psychosocial risk is a risk to the health or safety of a worker or other person arising from a psychosocial hazard.³⁵ Part 3.1 of the WHS Regulations³⁶ includes regulation 35, which provides that a duty holder, in managing risks to health and safety, must:</p> <ul style="list-style-type: none"> • eliminate risks to health and safety so far as is reasonably practicable, and • if it is not reasonably practicable to eliminate risks to health and safety, minimise those risks so far as is reasonably practicable.
Reasonably practicable	<p>Under the WHS Act, what is ‘reasonably practicable’ in relation to a duty to ensure health and safety, means that which is, or was at a particular time, reasonably able to be done, taking into account all relevant matters, including:</p> <ul style="list-style-type: none"> • the likelihood of the hazard or risk occurring³⁷ • the degree of harm that might result³⁸ • what the duty holder knows, or ought reasonably to have known about the hazard or the risk,³⁹ and ways of eliminating or minimising it.⁴⁰

Source: Definitions taken from *Work Health and Safety Regulations 2011* (Cth) and *Work Health and Safety Act 2011* (Cth).

31. Since the commencement of the WHS Act in 2012, section 4 of the Act has defined ‘health’ to include psychological health. Since then, managing psychosocial risks has been an essential function of Defence under its WHS Act section 19 primary duty of care.

32. In April 2023, the WHS Regulations relating to psychosocial risks and hazards were introduced. This was in response to a recommendation from Ms Marie Boland's Review of the Model Work Health and Safety Laws (the Boland Review) in 2018. The review recommended that the regulations be amended to identify the psychosocial risks associated with psychological injury and to set out the control measures to manage those risks.⁴¹
33. These regulations did not create new duties; rather, they explain Defence's primary duty of care to ensure psychological health. Defence was required to have had systems and controls to effectively manage psychosocial risks before the new regulations came into effect.

Governance of WHS within Defence

34. In fulfilling its duty of care, Defence has a Work, Health and Safety Board (WHS Board) and an Independent Audit and Risk Committee chaired by an external representative.
35. The Defence Audit and Risk Committee (DARC) oversees the enterprise risk management system, and advises on audit, risk and governance issues. It 'reviews and provides independent written advice to the [Defence] Secretary and Chief of the Defence Force on the appropriateness of Defence's accountability and control framework' across finance, performance, risk and systems of internal control.⁴²
36. The WHS Board is responsible for monitoring and improving the WHS of Defence workers. It provides due diligence assurance to Defence group heads and service chiefs that WHS risks are being managed.⁴³ This includes assessing Defence's WHS performance and legislative compliance, and helping to improve Defence's management of WHS initiatives.⁴⁴
37. The WHS Board is responsible for:

Welfare and wellbeing, mental health and suicide, suicidality and self-harm as it relates to enterprise-wide work health and safety strategic issues, in order to [consider] the nexus between these topics and work health and safety performance, legislative compliance, strategy, risk, initiatives, processes and procedures.⁴⁵
38. The WHS Board comprises a representative of each of the groups within the Department of Defence and the three services – Navy, Army and Air Force.⁴⁶ These representatives are expected to attend every meeting, and provide advice and guidance relevant to their respective areas and how this will impact Defence.⁴⁷ They must inform their respective group or service of all WHS Board decisions and information.⁴⁸ A Comcare representative is a permanent guest of this board.

13.2 Improving oversight of psychosocial risk management

39. The Defence Risk Management Framework states: 'Risk Management is integral and essential for successful corporate governance, as it improves decision-making, enhances accountability and supports the delivery of objectives'.⁴⁹
40. In this chapter, we discuss 'enterprise risks', which refers to 'risks that have the potential to impact ability to achieve strategic objectives'.⁵⁰ The Defence Risk Management Framework recognises the link between effective risk management and enterprise performance.
41. One of the 11 Defence enterprise risk categories is WHS, which captures 'psychosocial health' risks.⁵¹ Defence is required to implement control measures to manage psychosocial risks and to prevent or reduce harm.⁵² The application of the Defence Risk Management Framework guides that process.
42. In this section, we consider:
 - the absence of service-related risk factors that contribute to suicide and suicidality as either an enterprise risk (as discussed in Chapter 11) or a WHS priority
 - limitations in psychosocial risk management, including categorisation and controls
 - opportunities to enhance enterprise governance in the context of risk management.

13.2.1 WHS and enterprise risk priorities are silent on suicide and suicidality

43. Defence makes no specific reference to suicide or suicidality when capturing risk as an enterprise risk or a WHS priority.
44. In March 2023, the Defence People Committee received a copy of the Bi-annual Enterprise Workforce Report.⁵³ The report 'provide[s] a mid-cycle update on the status of Defence's workforce, and new and changing external factors likely to impact Defence recruitment and retention'.⁵⁴
45. An environmental scan was attached to the report, identifying and monitoring factors internal and external to Defence that may impact its future direction. Neither the workforce report nor the environmental scan made any reference to suicide, self-harm or psychosocial safety.⁵⁵ References to 'health' and 'wellbeing' were scant and mostly confined to a single page annex relating to initiatives in place within the Royal Australian Navy.⁵⁶

13.2.2 Defence's overarching risk management system lacks a psychosocial risk focus

46. We have some concerns with Defence's oversight of psychosocial risk and incident management. We found that psychosocial risk identification and categorisation has not always reflected evidence of risk. Controls have also focused on activity (that is, training) and have not measured the effectiveness of those activities in eliminating or reducing risk.

Enterprise controls for psychosocial risk are inadequate

47. Since 2019, Defence has produced an annual Enterprise Risk Report, which is described as:

an assurance report on the effectiveness of enterprise risk management in Defence and provides an assessment of the status of enterprise risks and the effectiveness of enterprise risk controls. The report is based on data from Group and Service business plans, performance reports, and inputs from Risk Stewards and control owners.⁵⁷

48. The committee with responsibility for exercising strategic control over Defence enabling functions (the tier two-level Enterprise Business Committee, chaired by the Defence Associate Secretary) receives a copy of the annual Enterprise Risk Report as part of risk assurance measures. The Defence Risk Management framework states: 'Risk management supports decision-makers by reducing the likelihood of risk events, minimising the adverse effects of risk events, and by promoting innovation in maximising opportunities'.⁵⁸
49. Defence Associate Secretary Mr Matthew Yannopoulos PSM told us the report was an attempt to bring together all of the risk information to help Defence understand if risks are being managed and mitigated effectively.⁵⁹
50. The report includes a dashboard focused on the effectiveness of controls against each of the enterprise risks, as well as a collective assessment of control effectiveness. Risk controls are assessed in terms of the following four categories:
- effective
 - partially effective
 - not effective
 - not measured.⁶⁰
51. The 2023 Enterprise Risk Report, which included a matrix of the risk controls against each risk category, and their respective effectiveness, was provided to the Enterprise Business Committee in November 2023.⁶¹

52. The briefing to the committee accompanying the report said: ‘The Report highlights that Defence’s enterprise risks are trending outside of the organisation’s risk appetite of “Low” to “Medium”’.⁶² On managing risk, the report said, ‘the overall control effectiveness status for October 2023 has been assessed as “not effective”, with only 49% of controls being reported as “Effective”’.⁶³
53. Seven risks are listed in the report under the WHS category, including psychosocial health and body stressing (which encompasses muscular stress, as well as repetitive movement with low muscle loading).⁶⁴ Against these WHS risks, only one singular control was listed – that is, ‘mandatory work health and safety training’, which was marked as being ‘effective’.⁶⁵
54. When asked how many enterprise-level WHS risk controls Defence has regarding psychosocial health and body stressing, Assistant Director of the Defence WHS Branch Mr John Love stated:
- The ... two primary controls in which we manage work health and safety enterprise risk is [sic] our Work Health and Safety Strategy and its implementation and our mandatory work health and safety training. Both have a focus on psychosocial hazards. So there’s two primary controls.⁶⁶
55. Mr Yannopoulos similarly told us that, despite not being listed in the Enterprise Risk Report, there was also a second control in place in addition to the mandatory WHS training: the Defence WHS Strategy.
56. The Draft WHS Strategy Implementation Plan contains a number of performance indicators relevant to the management of risk.⁶⁷ It is unclear why both controls were not listed on the Enterprise Risk Report. Both are applicable enterprise-wide, and the report is intended to provide senior leaders, including duty holders, with visibility of the effectiveness of controls.
57. A key tenet of effective governance is the ability to identify and respond to risks early, and mitigate any impacts that may result from realised risks; that is, a risk that has actually materialised. Having a complete picture of the status of enterprise risk management is the foundation of that capability, and supports accurate and effective decision-making. In the context of WHS, the consequences of risk realisation can be severe. The absence of a key control from the Enterprise Risk Report reduces the ability of senior leaders to make informed decisions to reduce risk factors that contribute to suicide and suicidality for Defence personnel.
58. When prompted on how Defence assesses the effectiveness of the mandatory WHS training control, Mr Love replied:
- In terms of we have an understanding of who’s completed it and when and – and how many. In terms of effectiveness and the impact on the Defence work health safety management system, I don’t think we do know.⁶⁸

59. In clarifying whether Defence understood whether the mandatory WHS training was contributing to change in the workplace, Mr Love said, 'I don't have the evidence to say that that control has impacted the entire organisation in a certain way, no'.⁶⁹
60. The assessment of the control is based on completion rates rather than any evaluation of the actual effectiveness of training in transferring knowledge and/or skills to the workplace.
61. Moreover, an assessment of the control effectiveness in August 2023 stated that mandatory WHS training had not been updated since 2020.⁷⁰ This meant that the new WHS Regulations addressing psychosocial risks and hazards, which came into effect in April 2023, had not yet been reflected in the training module.⁷¹ Internal advice to the Defence Committee, dated June 2024, notes that mandatory WHS training is currently under revision.⁷² As part of this, Defence should update its training to reflect all relevant changes made to the WHS Act and WHS Regulations to date.
62. Mr Love agreed that further controls could be put in place to better reduce risk. In responding to a question about the limitations of Defence in proactively identifying and managing psychosocial risks, Mr Love stated:

I think the challenge with psychosocial hazards and risk is the ability to measure it, and I think it's quite hard to measure at the enterprise level against the Safe Work Australia listed hazards.⁷³

Mental Stress Review highlights issues with WHS governance of psychosocial risk and incidents

63. In January 2020, the Defence People Group presented its biannual risk report to the Enterprise Business Committee. The risk report identified six hazards as areas of focus, one of which was mental stress.⁷⁴
64. The Defence People Group led a subsequent investigation into mental stress. The review included representatives from Defence, each service and the Department of Veterans' Affairs (DVA). It analysed data from sources covering January 2019 to June 2021, and produced the *Work Health and Safety Focus Area: Mental Stress* report.⁷⁵
65. The report identified a 39% increase in the number of reported mental stress incidents and an 86% increase in the number of people involved in those incidents over 5 years. It flagged mental health as a priority for Defence.⁷⁶

66. The key findings were described as follows:

Within the Department of Defence nearly a third of people involved in mental stress incidents, as reported in the Defence Work Health Safety Management Information System, were exposed to a traumatic event and most of those were ADF members (88%).

Most incidents reported in the Defence Work Health and Safety Management Information System as 'suicide or attempted suicide' involved ADF members (97%). A third of these reports were ADF youth cadets.

Females reported mental stress incidents at a significantly higher rate than males in both APS [Australian Public Service] and ADF, bullying and harassment was reported in higher numbers by females, and females were more likely to seek help with the Employee Assistance Program or New Access.

Overall, the highest number of reports in the Defence Work Health and Safety Management Information System occurred in the 25–34 age groups, though the rate of reporting per 1000 employees peaked in the under 20 and over 50 age groups.

The mental health screening tests relating to ADF members conducted over the last two financial periods indicate a general increasing trend in the percentage of members who scored in the moderate to very high brackets, indicating that more members may be identified as needing further mental health assessment.⁷⁷

67. In terms of the notifiable incidents, 46% were suicide or attempted suicide incidents.⁷⁸ These were classified as a 'fatality' or 'serious injury', which meant they were notifiable incidents and had to be reported to Comcare. We note that other suicide attempts were categorised as a 'minor injury' or 'near miss', which are not notifiable incidents. We are concerned that not all suicides or suicide attempts are considered notifiable events.⁷⁹
68. Members of the WHS Branch then held a workshop with other parts of Defence to examine causes of mental stress, and prevention and mitigation risk management control factors.⁸⁰ The participants produced a Mental Stress Risk Bowtie diagram identifying both proactive and reactive risk management control factors. A 'bowtie' diagram illustrates the risk an organisation is dealing with. It is shaped like a bowtie to show the difference between proactive and reactive risk management.
69. They then assessed many of the control factors according to how critical they were to Defence, and their perceived effectiveness. Of the 85 control factors identified, 19 were not assessed. Of those that were assessed for effectiveness, four were rated as 'not effective', 47 as 'partially effective' and 17 as 'mostly effective'.⁸¹ No control factors were rated as 'effective'.⁸²
70. The four factors deemed 'not effective' related to due diligence, organisational learning about workplace psychosocial hazards, performance management and succession planning. All were rated as having '[high] criticality'.⁸³

71. WHS Branch Assistant Secretary Mr Love was asked whether this painted a concerning picture of Defence's ability to respond to the risks identified. He replied:
- ‘Yes’ and – and ‘no’. I think that this work was valuable in identifying controls and providing a quick assessment on the criticality of those controls. It was very exploratory, with a small group of members from, as you mentioned, my branch and a number of parts of the organisation, and improved our understanding of, you know, those controls that are in place. There was other work alongside this, so we didn't look at this work in isolation.⁸⁴
72. Mr Love agreed the findings of the mental stress report highlight ‘the need to improve Defence's capability to respond effectively to psychosocial risk’.⁸⁵
73. The branch included the workshop outcomes in a completion report along with findings from its extended analysis of the Mental Stress Risk Bowtie. The completion report noted the extended analysis ‘identified gaps in the assessment of preventative/ mitigative control types and their effectiveness ratings’ that led to:
- (i) a lack of understanding of due diligence and how lessons learnt are applied retrospectively – in particular, the forecasting of risks associated with mental stress
 - (ii) an inability to determine how policy contributes to being an effective control mechanism – in particular, how workers are consulted on policy development and supporting systems
 - (iii) uncertainty of how performance monitoring is measured – in particular, how intervention strategies are used to combat further psychological or physical trauma.⁸⁶
74. The completion report identified eight opportunities for improving ‘mental stress safety management performance’. These included improving the quality of data, data analysis, succession planning, leadership as it relates to performance management, and the evaluation of the effectiveness of the ADF's chaplaincy and health system. Both of the latter were assessed as ‘highly critical’ control factors; however, their effectiveness is unknown.⁸⁷
75. Defence has stated that given its large size, complexity and diversity, ‘there is a real question of whether it is possible to comprehensively assure absolute compliance with enterprise-level policy changes that seek to reduce psychosocial harm’.⁸⁸ The diversity and immensity of Defence's workforce of nearly 100,000 people was acknowledged by the then Chief of the Defence Force during Hearing Block 12.⁸⁹ However, there is no definitive evidence from Defence witnesses that the scale of Defence means that it is unable to assure absolute compliance with enterprise-level policy.
76. We recognise that Defence's approach to WHS assurance is maturing as demonstrated by its ongoing work to implement assurance activities against the Defence WHS Strategy 2023–2028, as well as its WHS Lessons Learnt Framework.⁹⁰

Limited oversight of actions responding to the Mental Stress Review findings

77. The WHS branch provided the completion report to the WHS Board in August 2022. The board considered it alongside other hazard area reports. Talking points summarised the key Mental Stress Review findings as follows:

The work concluded that the majority of mental stress initiatives were seen as maturing, and emerging Mental Stress initiatives need to be revisited in order to further understand psychosocial risks to both personnel and Defence capability.⁹¹

78. The talking points also noted that Defence had recently been charged with three WHS Act offences in relation to a suicide event.⁹² Although the talking points indicated these charges were not unexpected, they also stated that ‘it certainly underscores how important it is to get physical and mental safety right for our people and our enterprise’.⁹³
79. The minutes of the meeting do not indicate any discussion of the Mental Stress Risk Bowtie, the assessment of the 85 preventative and mitigative barriers identified, or the eight identified areas for improvement.⁹⁴ In our view, it did not receive the attention required to enable next steps to be thoroughly considered.
80. The Mental Stress Review provided the WHS Board with specific contributors, preventative and mitigative factors to psychosocial stress in the workplace with suicidality links. This was relevant to Defence’s responsibilities under regulation 35 of the WHS Regulations to ‘eliminate or minimise’ risks ‘so far as is reasonably practicable’.⁹⁵
81. The Mental Stress Review completion report stated the Defence People Group would ‘incorporate initiatives and programs that have an impact at an enterprise level into the Defence Work Health and Safety Strategy Implementation Plan’.⁹⁶ The Chief of the Defence Force and Secretary endorsed the WHS Strategy 2023–2028 in November 2023.⁹⁷ However, neither the WHS Strategy nor the draft WHS Strategy Implementation Plan contains any reference to ‘mental stress’.⁹⁸
82. We sought details from Defence about how it had responded to the Mental Stress Review findings, but it provided no implementation or action plans.⁹⁹ Nor did it provide any materials that demonstrate work to address the prevention and mitigation factors found to be partially effective or ineffective, or plans to reduce exposure to psychosocial stress at work.
83. When asked about the absence of the Mental Stress Review findings from the WHS Strategy in Hearing Block 12, Mr Love indicated that Defence had shifted its focus to ‘psychosocial hazards’, noting that this represented a shift in terminology. He said:

The mental stress terminology and the analysis we were doing there shifted to psychosocial hazards and risk, so that’s what has moved into the Work Health and Safety Strategy.¹⁰⁰

84. However, Mr Love also said that '[i]n terms of hazards, I don't think mental stress is, in the technical sense, considered a hazard, a psychosocial hazard'.¹⁰¹
85. This is despite the Defence WHS quarterly dashboard listing mental stress as one mechanism of psychosocial injury.¹⁰² We discuss the dashboard in section 13.3.1. The dashboard for the first quarter of 2024, which is the most recent dashboard seen by us at the time of writing this report, shows that mental stress remains the number one mechanism of psychosocial injury across Defence.¹⁰³
86. In the absence of a consistent and defined view of psychosocial hazards, including mental stress, developing targeted and effective risk controls is likely to be challenging.

Improving information provision for decision-makers

87. Defence Associate Secretary Mr Yannopoulos has responsibility for enterprise governance and risk management assurance functions. The Risk Steward for both the Workforce and WHS risk categories is the Deputy Secretary, Defence People Group, a position reporting directly to the Associate Secretary.
88. When asked via notice about the Mental Stress Review, Mr Yannopoulos said, 'I was not aware of this paper prior to receipt of this notice'.¹⁰⁴ He agreed that he would have expected to have known about it. When asked whether this was demonstrative of a governance blind spot, Mr Yannopoulos said:

Well, it's a blind spot to me. Yes, a decision was taken within the board – well, or by an act of omission that that was not provided up to EBC [Enterprise Business Committee] for us to – because when you look at 42 partially effective and four not effective, we clearly aren't looking to do the right things.¹⁰⁵

89. Mr Yannopoulos agreed this meant he could not ensure something was done about the findings.¹⁰⁶
90. In his statement, Secretary of the Department of Defence, Mr Greg Moriarty AO, stated:

Defence's WHS Committee structure informs the CDF and I of health and safety matters for Defence personnel, as directed in the WHS Strategy and Commitment Statement ... Biannual updates are provided to the Defence Committee and Enterprise Business Committee. Where, through reporting, I have observed trends in WHS incidents, I take action to have these matters discussed and addressed.¹⁰⁷

91. Escalating issues of concern relies on integrity and transparency within committee structures. In this instance, despite Defence placing trust in them, those structures have not adequately responded to significant risks to Defence people. The draft WHS Strategy Implementation Plan acknowledges:

there is no high level document that outlines the structure [or] the management of enterprise level WHS risk, how it connects with the Defence Enterprise Risk Framework, the enterprise WHSMS and Group and Service-level risk policies.¹⁰⁸

92. Defence needs to strengthen both the individual and collective accountability of senior members charged with ensuring compliance with WHS requirements that are intended to protect workforce safety and wellbeing.
93. Former Sex Discrimination Commissioner, Ms Elizabeth Broderick AO, who led the Review into the Treatment of Women in the ADF, noted the opportunity that exists in ‘leveraging the safety infrastructure’ to address risks to wellbeing and reinforce positive behaviours. She noted that ‘many organisations that are doing this well are now attaching this agenda to the WHS agenda’.¹⁰⁹ Ms Broderick said:
- I think that is the opportunity for the ADF at the minute, that these psychosocial risks that were always there and continue to be there can be addressed in a much better way through the safety infrastructure. Because if you were to look at that, someone who comes forward to identify risk in the organisation, just as they do with physical risk, is celebrated. So similarly, there should be a celebration of someone coming forward who is identifying a psychosocial risk like sexual harassment. So that’s the shift.¹¹⁰
94. The Mental Stress Review shows that Defence collects evidence about psychosocial risk hazards. A critical next step in effectively reducing risk and harm will be to continue developing enterprise-wide systems that enable the thorough use of that information.

Psychosocial risk management has not always reflected the evidence base

95. In October 2022, the Defence WHS Board agreed to make psychosocial risk a focus area, with a commitment to:
- report on psychosocial [risk] biannually and to progress five lines of effort to mature the Defence enterprise approach to psychosocial risk including: guidance and tools; education, training and programs; surveillance; governance; and assurance.¹¹¹
96. In August 2023, WHS Board members received an update on and copy of the Biannual Defence Work Health Safety Psychosocial Report spanning data from 2018 to 2022. The update noted a key finding from the report was that:
- [p]sychosocial incident reports have been trending upwards over the 5 year period, with the number of people involved in psychosocial incidents more than doubling. This was most evident in the Services, particularly in the last 2 years, with reports by ADF members and ADF cadets trending up, but reports by APS [Australian Public Service] employees trending down.¹¹²
97. Despite this, the WHS Enterprise Risk Report produced 2 months later, in October 2023, rated the likelihood of exposure to psychosocial hazards at work as ‘improbable’.¹¹³

98. Defence made similar assessments for the organisation-wide risk associated with ‘body stressing’. According to the enterprise risk matrix, the likelihood of experiencing a musculoskeletal injury was also classified as ‘improbable’.¹¹⁴ However, according to Defence’s own figures, it accounts for 22% of all WHS incidents.¹¹⁵
99. An ‘improbable’ risk likelihood stands in stark contrast to the information provided to the board, where the reporting of actual incidents indicates that the hazards and risks were not only being realised but were increasing.
100. Despite variable risk scores across the individual hazard areas, Defence rated each of the seven WHS enterprise risks as ‘improbable’ in the October 2023 risk report.¹¹⁶ Defence did not consider all available contextual information when determining risk likelihood.
101. ‘Improbable’ is defined by Defence as ‘more likely than rare, but less likely than occasional’.¹¹⁷ According to Defence:
- Enterprise risk categorisations are based on evidence. The evidence indicates that as a matter of statistics, it is improbable ... that a Defence member will be involved in a psychosocial incident. That is due to the very low number of reported psychosocial incidents per year compared to the ADF member population.¹¹⁸
102. In making this claim, Defence cites the baseline number of ADF members involved in notifiable and non-notifiable psychosocial incidents between 2018 and 2023.¹¹⁹ However, such an approach is not as statistically sound as Defence suggests because Defence has noted data quality issues with its WHS statistics (see Appendix I, Comparative rates of suicide – ex-serving ADF members).
103. The terms ‘rare’ and ‘less likely than occasional’ used by Defence are not defined statistical terms.
104. In Defence’s WHS statistics, psychosocial incidents include mental stress and workplace bullying. Survey data for 2018 to the first quarter of 2023 shows that more than 15% of permanent ADF members reported experiencing bullying in the previous 12 months (see Appendix L, Defence survey data). We do not believe an event that is experienced by 15% of the permanent force can be reasonably categorised as ‘improbable’.
105. This approach does not account for other sources of information that may be relevant to understanding psychosocial risk (such as unacceptable behaviour) or the psychosocial wellbeing of current serving members. For example:
- Data from 2018 to the first quarter of 2023 showed that more than one in three permanent ADF member survey respondents experienced unacceptable behaviour in the previous 12 months. The survey data also showed that those who experienced unacceptable behaviour were at greater psychosocial risk than those who did not experience unacceptable behaviour. (see Appendix L).

- The 2021 Census showed that 7% of serving members have a long-term mental health condition.¹²⁰ Further, research from the Transition and Wellbeing Research Programme in 2018 found that 10.8% of members serving in the permanent forces reported ‘very high psychological distress’.¹²¹

106. We are concerned that rating the likelihood of psychosocial incidents as improbable based on low numbers alone may fail to take account of the degree of harm in circumstances in which the consequences can be severe and include suicide. This is reinforced by a WHS Longitudinal Analysis produced by Defence and current as at March 2024, which shows that when mental stress is the mechanism that causes injury, the likelihood of the ‘Event Severity’ being a fatality increases by 121.66 times.¹²² This far exceeded figures of other mechanisms causing injury; for example, where the ‘object causing injury is other person’, the likelihood of the Event Severity being a fatality increases by 10 times.¹²³
107. We welcome the longitudinal analysis as one demonstration of recent efforts to further understand drivers of WHS incidents. However, we also remain concerned that Defence has not historically classified psychosocial-related risk likelihood effectively, and has therefore missed opportunities to target and scale interventions appropriately.

Recommendation 55: Conduct an audit into Defence workplace health and safety risk management

The Defence Audit and Risk Committee should commission an audit into Defence workplace health and safety (WHS) risk management within the next 12 months. The audit should include, but not be limited to:

- (a) reviewing WHS hazard trends with a focus on psychosocial health and compliance with requirements of the *Work Health and Safety Act 2011* (Cth)
- (b) reviewing the accuracy of existing WHS enterprise risk reporting, including the WHS dashboard
- (c) assessing WHS risk-assessment methodology, and the accuracy of categorisations of ‘likelihood’ and ‘impact’ of hazards within the ‘WHS’ enterprise risk category
- (d) assessing the suitability and effectiveness of WHS hazard controls, including their ability to be measured for impact.

The findings of the audit must be reflected in the delivery of the Defence WHS Strategy and WHS risk reporting going forward.

13.3 Poor data and analysis hampers prevention and early intervention

108. It is critical that Defence collects and analyses data relating to the psychosocial harm experienced by ADF members in connection with service. Such data and analyses will inform the implementation of effective early intervention and preventative measures to address psychosocial harm, including latent harm.¹²⁴
109. ‘Latent harm’ refers to ‘injuries or illnesses, including psychological conditions ... [that] may have a slow or delayed onset, manifesting sometime after exposure to a particular hazard in the workplace’.¹²⁵
110. As we note in Chapter 29, Use of data and research by Defence and DVA, we have concerns about the completeness of Defence’s WHS data prior to 2014 (at which time information was recorded on paper forms). See Appendix L, Defence survey data.
111. In this section, we consider the obstacles to establishing a robust evidence base and undertaking trend analyses that will allow Defence to identify the root causes of hazard and incident trends. Defence needs to understand these factors well to implement risk management, prevention and early intervention strategies that can reduce psychosocial harm to members.
112. The quality, accuracy and visibility of psychosocial incident data is poor because:
- Defence data systems and analysis do not allow data to be appropriately interrogated to identify the causes of incident trends
 - the legislative definition of ‘notifiable incidents’ is narrow and limits what psychosocial incidents are reported to Comcare
 - Defence incident notification practices are inconsistent.

13.3.1 Defence data does enable meaningful trend analysis

113. Defence records both notifiable and non-notifiable psychosocial incidents in a WHS Quarterly Dashboard.¹²⁶ According to Defence:

Drawing data from across multiple systems and areas of Defence, this dashboard highlights WHS risk across the organisation, allowing decision-makers to proactively take appropriate action in addressing areas of concern.¹²⁷

114. Ms Justine Greig PSM, Deputy Secretary, Defence People Group, told us she uses the dashboard ‘as a tool to generate conversation at the [Secretary/Chief of the Defence Force] Roundtable quarterly to ensure Groups and Services are considering their safety data and the processes in place to address trends’.¹²⁸ Defence told us the dashboard has interactive functionality to enable representatives from Defence groups and the three ADF services to ‘drill through to incident details to support their own analysis’.¹²⁹

115. When we sought further information on the use of this functionality, the ADF clarified:

Groups and Services do not use the Quarterly Dashboard in isolation to identify trends and risks. The Dashboard alone does not provide Groups and Services the detailed information required to understand psychosocial related trends and risks in their contexts.¹³⁰

116. Defence further explained that:

[i]n addition to the WHS Quarterly Dashboard, Groups and Services representatives can drill down into their Group or Service level WHS data through their approved access to the Safety Trend Analysis and Reporting Solution (STARS) or directly within [Defence's WHS Management Information System] Sentinel.¹³¹

117. The psychosocial data captured in the dashboard is generic, as Defence itself has acknowledged.¹³² Defence explained that it records the number of incidents that compromise a person's safety, as well as the total numbers of such incidents across different areas. It said this is insufficient to accurately identify trends, or capture lessons or insights. This is because analysing the root cause would require access to the affected individual's health records.¹³³

118. In his testimony during Hearing Block 12, Assistant Secretary for the WHS Branch, Mr Love, conceded that:

there's some work to do with the system because it's not perfect in terms of capturing the root cause and specific hazards related to psychosocial hazards, the data that falls out of it isn't quite meeting what we need at this very time.¹³⁴

119. Defence acknowledges that the data captured in its WHS management information system, Sentinel, does not allow for complete analysis of the root causes of psychosocial injury and harm.¹³⁵ To the extent that Sentinel does capture this information, via a root cause field, there is evidence that this field is not consistently completed by individuals.¹³⁶ Defence also acknowledges that 'more fields could be included to enable better data capture'.¹³⁷

120. Defence explained the dashboard only shows the total number of incidents that occur in each group or service; that is, it does not take into account differences in personnel numbers.¹³⁸ Not knowing the proportion of events per person or per capita makes it very difficult to identify problem areas or compare the safety records of one area with another.

121. Given the dashboard limitations, the Air Force has shown the most interest in conducting analyses to better understand psychosocial trends and risks. The Air Force has done so using additional data sources, including longitudinal three- to five-year Snapshot trends, Force Element Group Safety Management System trends, Defence Incident Reports and Sentinel reports.¹³⁹

122. Air Force has identified a number of trends, including job hindrances (that is, factors that make it more difficult for members to perform their roles effectively and efficiently), workload and fatigue. These are combined with other factors, such as uncertainty due to postings and short notice requirements to deploy.¹⁴⁰
123. Air Force engages senior data scientists and risk specialists to analyse datasets of factors impacting the health and wellbeing of its personnel each year.¹⁴¹ Despite this, the Air Force advises:
- To date, while data has been reviewed over five year periods, given the lack of frequency of more serious psychosocial reports combined with the lack of non-notifiable incidents, including near misses (lead indicators), limited to no meaningful trends have been identified as an outcome of the more serious [p]sychosocial reports, including because of the inability to track the root causes where it would require access to information from the individual affected member's health records.¹⁴²
124. Acknowledging these limitations, we commend the Air Force for identifying ways to access appropriate data and implement strategies to gain insight and understanding. We would like to see this sort of curiosity and effort applied broadly and consistently across Defence.
125. Defence should ensure all data practices support the effective management of psychosocial risk and protective factors related to ADF service.
126. It should collect, analyse, report and – subject to privacy considerations – share de-identified data and use it in ways to:
- identify root causes of and factors that contribute to psychosocial risk
 - identify trends in locations, activities or cohorts exposed to higher levels of psychosocial risk
 - share this data with the people and organisations who need it to fulfil their roles and responsibilities.
127. In June 2024, Defence advised us through the procedural fairness process that it has developed and released a new interactive WHS Incident Dashboard.¹⁴³ It is intended to 'complement the static Defence WHS Quarterly Dashboard and provide Groups and Services with ready access to WHS incident data and assistance with timely identification of insights and trends'.¹⁴⁴ This new interactive dashboard contains information about WHS incidents for the past five years 'using incident data sourced from Sentinel via the Safety Trend Analysis Reporting Solution (STARS)'.¹⁴⁵
128. Due to this being a recent development, we are unable to assess any measurable benefits arising from this new product, but acknowledge that it contains 'root cause analysis factors'. Incident numbers and percentages (as a proportion of the total number of incidents with at least one root cause) are detailed for each of the root cause factors.¹⁴⁶ We encourage Defence to continue to improve its approach to root cause analysis, so that this raw data on root cause factors can be easily translated by dashboard users into meaningful trend analysis to inform prevention efforts.

129. To continue maturing the dashboard, Defence should consider:

- reflecting multiple time points to analyse trends – this is not done consistently in the dashboards. For example, the WHS Quarterly Dashboard for the first quarter of 2023 only references earlier statistics in some of its charts.¹⁴⁷ Incorporating time comparisons – from the previous quarter, for example – will support trend analysis
- incorporating more data from its Case Management System (CASE) – Defence People Group’s Ms Greig notes the dashboard includes unacceptable behaviour data from Defence’s Complaint Management, Tracking and Reporting System (ComTrack).¹⁴⁸ However, we note CASE is to replace ComTrack and other unacceptable behaviour reporting systems, including Sentinel.¹⁴⁹ The dashboard should incorporate the broader range of information from CASE as appropriate. We note Sentinel data is not due to be integrated into CASE until 2026 at the earliest¹⁵⁰
- ensuring that root cause information is captured by CASE for the purpose of supporting trend analysis.

130. Other ways Defence has improved how it analyses and reports on WHS data include introducing a feedback mechanism to increase the visibility of and accountability for action taken in response to insights and trends identified in the WHS Quarterly Dashboard. It also introduced psychosocial risk reporting, with deep dives provided to the Defence WHS Board in April 2024 and the Defence Committee in May 2024.¹⁵¹ Defence also launched a new WHS Strategy in 2023. While we recognise these recent efforts at improvements, it is too early to assess whether they are having a positive impact.

131. Notwithstanding this recent activity, we reiterate that Defence has been aware of suicide risks since as early as 2002, and various WHS systems have been in place from before that time. As such, Defence has had a long time to mature its ability to conduct trend analysis of psychosocial harm. That this type of enabling and foundational work is still occurring in 2024 indicates the need for sustained focus on this issue.

132. The deficiencies we have identified here in Defence’s approach to analysing data are not unique to WHS incidents. They are symptomatic of poor data practices across Defence. Chapter 29 examines these issues in detail.

13.3.2 Improving Comcare’s visibility of psychosocial incidents

133. As the regulator, Comcare plays an important role in supporting prevention, early intervention and risk management strategies to mitigate or reduce psychosocial harm. Comcare receives data from Defence about notifiable incidents.

134. However, Comcare’s visibility of WHS incidents is limited due to the narrow definition of notifiable incidents. A broader government review on expanding this definition is underway. However, there is no reason why Defence should wait to share non-notifiable incident data with Comcare in an aggregated de-identified way to ensure it does not breach privacy laws. It should also share the meaningful analysis of this data that we recommend it starts to undertake. This would support Defence’s compliance with its WHS Act duties.

A narrow definition of notifiable incidents

135. Defence is only required to notify Comcare of anything meeting the definition of a ‘notifiable incident’ under section 38(1) of the WHS Act. The Act defines a notifiable incident as:

- the death of a person
- a serious injury or illness of a person
- a dangerous incident.¹⁵²

136. A ‘serious injury or illness’ refers to an injury or illness that requires immediate treatment as an in-patient in hospital, or immediate treatment for certain physical injuries.¹⁵³ It does not include out-patient treatment provided by a hospital emergency department.¹⁵⁴

137. This narrow definition (difficulties with its interpretation for incidents of psychosocial harm are discussed in section 13.3.3) limits the visibility Comcare has of psychosocial harm. Former Comcare CEO Ms Weston told us:

Incidents involving ‘harassment or bullying’, ‘psychological injury or illness’, ‘serious physical assaults’ and/or ‘serious sexual assaults’ fall outside of the scope of Notifiable Incidents ... within the meaning of the WHS Act, save for such incidents resulting in death, immediate treatment as an in-patient in a hospital, or immediate treatment for physical injury ...¹⁵⁵

If it doesn’t pass the notifiable test, if that is the problem, we don’t get the visibility of it in that way.¹⁵⁶

138. Comcare told us this adversely impacts its regulatory effectiveness:

Comcare has observed that the effect of its limited visibility of incidents arising from psychosocial factors and slower or delayed onset conditions, in turn curtails the effective and comprehensive design of a regulatory approach which specifically addresses latent harm.¹⁵⁷

Defence should not wait for legislative change to report non-notifiable incidents to Comcare

139. As Comcare CEO Mr Gregory Vines explained:

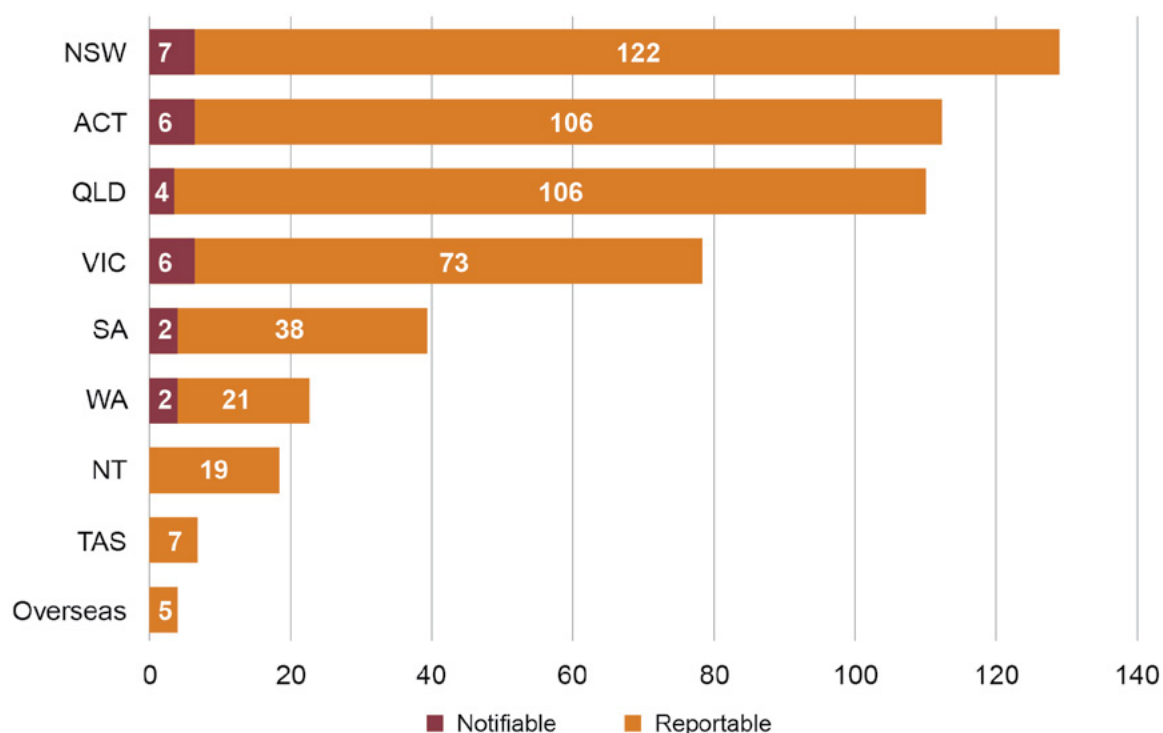
In practice, regulators are not always aware of when a psychological injury or illness has occurred within their jurisdiction. This is because, generally, incidents involving 'psychological injury or illness' presently fall outside the scope of a Notifiable Incident or Dangerous Incidents within the meaning of [sections] 35 to 39 of the WHS Act.¹⁵⁸

...

It is unusual that Comcare is notified of a fatality through means other than through the notification provisions under the WHS Act, i.e. an incident notification.¹⁵⁹

140. ADF data shows there are more non-notifiable psychosocial incidents for its members than notifiable psychosocial incidents.¹⁶⁰ For example, between January 2019 and June 2021, the number of 'reportable' mental stress incidents (that is, incidents that must be reported internally) in Defence parent locations outnumbered the number of 'notifiable' mental stress incidents that must be reported to Comcare (see Figure 13.1).

Figure 13.1 Number of incidents by top parent locations and severity group



Source: Exhibit F-03.049, Work Health and Safety Focus Area: Mental Stress, 1 January 2019 to 30 June 2021, DEF.1221.0001.0869 at 0896.

141. To address this gap, the Boland Review recommended the Australian Government ensure the WHS Act incident notification provisions provide a notification trigger for psychological injuries beyond those already required by the Act:

Review incident notification provisions in the model WHS Act to ensure they meet the intention outlined in the 2008 National Review, that they provide for a notification trigger for psychological injuries and that they capture relevant incidents, injuries and illnesses that are emerging from new work practices, industries and work arrangements.¹⁶¹

142. At the time of writing the final report, Safe Work Australia (Safe Work) was developing options and recommendations to improve the incident notification framework for Commonwealth, state and territory WHS ministers to consider. These ministers are the decision-makers in relation to amendments to the model WHS laws.¹⁶²
143. Comcare told us this work 'should continue to be progressed as a matter of priority, to comprehensively address gaps embedded within the incident notification provisions'.¹⁶³
144. Defence confirmed it has the resources and personnel within its WHS Branch to respond to any amendment of notifiable incident requirements. However, it will await the outcome of the government's incident notification review before acting.¹⁶⁴
145. Defence needs to be proactive to achieve its stated goal of becoming a world-class leader in safety culture and performance.¹⁶⁵ Indeed, Defence's WHS Strategy Implementation Plan 2023–28 states '[b]est practice is to identify risks and manage them proactively, rather than reactively'.¹⁶⁶
146. Comcare told us:

These gaps or barriers to Comcare being notified may still exist in relation to latent harm, notwithstanding the proposed amendments to incident notification provisions being progressed by [Safe Work Australia].¹⁶⁷

...

... [a]n unresolved challenge in respect to the notification requirements for latent psychosocial hazards is that it is difficult to pinpoint the precise point in time at which exposure to the risk would require the [duty holder] to notify the regulator.¹⁶⁸

147. To overcome this challenge, any broadening in the scope of notifiable psychosocial incidents needs to be supported by useful analysis by Defence.
148. We acknowledge Comcare can, under its own initiative and without being notified, obtain information, conduct an inspection or investigate incidents to monitor compliance with or investigate contraventions of the WHS Act.¹⁶⁹ However, Comcare needs to be aware of the incident through other means, such as media reports, tip-offs, and general safety concerns raised through other channels.¹⁷⁰ For example, Comcare became aware of allegations of bullying and harassment of officer cadets at Holsworthy Barracks through media reports and then conducted an inspection.¹⁷¹

149. Regardless of the outcome of the government's incident notification review, Defence should analyse data on both notifiable and non-notifiable psychosocial incidents and share this analysis with Comcare, subject to privacy requirements. In section 13.4.6, we recommend that this data be shared through engagement forums between Comcare and Defence. Visibility of this data would help Comcare regulate psychosocial harm within the ADF, particularly as Defence improves its approach to data analysis.
150. Evidence suggests that, currently, Defence data analysis is not consistently producing high-value insights that could inform preventative strategies for psychosocial harm. In Chapter 16, ADF healthcare services, we recommend that the ADF establish an enterprise-wide comprehensive injury surveillance and prevention program, encompassing physical and psychosocial risks and hazards. Among other things, this program should identify root causes or contributing factors at the time of the injury; actively monitor where injuries and psychological risks and hazards are occurring, and generate quarterly reports on injury rates and clusters with actionable recommendations for commanding officers.

13.3.3 Inconsistencies in Defence incident notification

151. There are inconsistencies in Defence's practice to report notifiable incidents that mean Comcare is unlikely to obtain a complete picture of notifiable incidents. This is driven by:
- uncertainty and confusion within Defence over how to determine if an incident is connected to ADF service (that is, the 'service nexus') and so reportable to Comcare
 - unclear Defence guidance on how to determine whether psychosocial incidents should be notified to Comcare
 - a lack of quality assurance for service nexus determinations made by Defence.
152. These issues mean incidents that should be notified are not notified. An accurate picture of incidents is critical to ensure harm is identified, causes are understood and strategies to reduce or mitigate these harms are in place.

Lack of clarity about the service nexus

153. Under the WHS Act, a notifiable incident is one that arises out of the conduct of Defence's business or undertaking.¹⁷² That is, for the incident to be notifiable to Comcare, the ADF must establish there is a connection or nexus between the incident and ADF service – a so-called 'service nexus'. Neither the WHS Act nor the WHS Regulations use the phrase 'service nexus'; however, we have adopted it as a shorthand for the connection to service.

154. Defence provided us with its internal guidance on this issue. The guidance instructs a commander, manager or workplace supervisor to notify Comcare immediately by phone after becoming aware that a notifiable incident has occurred. They must record the incident in Defence's primary WHS reporting system, Sentinel, within 24 hours.¹⁷³ Once all the required actions are completed in Sentinel, a written notification is automatically sent to Comcare as required under the WHS Act.¹⁷⁴

155. It is up to Defence to determine first that there is a connection to service.¹⁷⁵ This directly impacts the accuracy of the notifiable incident data provided to Comcare.¹⁷⁶

156. The WHS Act provides no criteria for making this determination, and the Comcare guidance is not definitive, stating:

When assessing whether an incident arises out of the conduct of its business or undertaking, the PCBU [person conducting a business or undertaking] should consider the broad range of activities that can be attributed to the business or undertaking. It is also important to be aware that although there must be a connection between the business activities of the PCBU and the notifiable incident, these business activities may not be the direct or sole cause of the notifiable incident.¹⁷⁷

157. Similarly, a Safe Work Australia information sheet on incident notification only provides examples with respect to physical, not psychological, injuries or illnesses.¹⁷⁸

158. Determining a service nexus for incidents involving psychosocial harm is complex. In part, this complexity is addressed by Defence's 'if in doubt, notify' policy that encourages ADF members to notify Comcare,¹⁷⁹ including when they are unsure whether there is a 'service nexus'. Comcare promotes the same policy for all its duty holders.¹⁸⁰

159. To promote this, Defence provides incident reporting training and education to its workforce, including commanders, managers and others responsible for reporting incidents.¹⁸¹ Despite this, confusion over the service nexus for psychosocial harm incidents persists.

160. Comcare CEO Mr Gregory Vines told us that, for incidents of suicide:

we have to assume there is a nexus, unless it is proved that there is not one in some of these cases ... There may well be other contributing factors ... but that does not deny the work relationship or the service nexus ...¹⁸²

161. Mr Vines noted the act of notifying incidents to Comcare does not necessarily mean they are 'notifiable' under the WHS Act.¹⁸³ Rather, Mr Vines explained that doing so 'at least lets us get in and see whether it is a work-related issue and make that determination'.¹⁸⁴

162. WHS Branch Assistant Secretary Mr Love identified two primary documents that guide Defence workers on how to make ‘service nexus’ determinations for psychosocial incidents: The Psychosocial Risk Management Policy, published in November 2023, and a document titled ‘Guidance 01 – Notification of Psychosocial Incidents to Comcare’.¹⁸⁵
163. We acknowledge Defence’s efforts to provide greater clarity, but the guidance is not sufficiently clear. Neither document expressly instructs workers to notify Comcare if they are ‘in doubt’ as to whether an incident meets the notification threshold. Nor do the two guidance documents set out a clear decision-making process for determining a service nexus for psychosocial incidents and when to notify such incidents to Comcare.
164. Mr Vines told us it was up to Defence to make it simple and straight forward:

I think part of the problem lies in a lack of clarity in the way it is described in Defence ... there isn’t anything for Comcare to be clarifying [with Defence, about the service nexus]. I think Defence could be a bit clearer in more simple terms as to what it means: unless there’s no doubt, or if there’s any doubt, refer. I think it needs to be as simple as that, but, unfortunately, in some of the documents I’ve read, it starts to get a lot more complicated as to what they mean by that.¹⁸⁶

Confusion about ‘if in doubt, notify’

165. We heard evidence of confusion over the ‘if in doubt, notify’ policy at senior levels of Defence and Comcare.
166. Mr Vines confirmed that the practical effect of the ‘if in doubt, notify’ policy should be that Defence notifies Comcare of all ADF member suicides, unless such a death ‘can clearly ... without doubt, be excluded’.¹⁸⁷
167. However, Mr Love told us Defence does not, as a matter of course, report all member deaths by suicide to Comcare, as there is no Defence policy that requires it.¹⁸⁸
168. A commanding officer told us instances of suicide or suicidal ideation had not been reported to Comcare because contributing factors other than ADF service were present.¹⁸⁹ Comcare told us it raised the officer’s testimony at a meeting with Defence, and Defence advised that it has no policy, guidance or training that supports the officer’s adopting this approach.¹⁹⁰ However, this highlights the confusion about applying the policy in practice.

169. The February 2023 Vice Chief of the Defence Force Executive's Safety Board meeting outcomes highlight this confusion about 'if in doubt, notify' at senior levels in the ADF:

Comcare is still reviewing the notification requirements for psychosocial risks but has recommended erring on the side of caution, even if the member is not admitted to hospital, and notify if in doubt. There is a disconnection between current legislation and what Comcare are asking Defence to notify ... [Assistant Secretary of Work Health and Safety] recommended current incidents be recorded as exposures or minor injury and that [Defence People Group] is working on interim guidance on how to determine the 'work-related' threshold ... [The Head of Military Strategic Commitments] raised the perceived career consequences of reporting, given the lack of clear definitions currently inherent with psychosocial risks. [Vice Chief of the Defence Force] reiterated that there is the function to protect privacy by having reports raised anonymously but noted the concern raised is valid.¹⁹¹

170. This confusion is also illustrated through Comcare inspection reports. Although the ADF is responsible for determining whether a service nexus exists in the first instance, Comcare can also determine the existence of a service nexus through its inspections. Comcare can conduct inspections to monitor and improve compliance with the WHS Act and may then make service nexus determinations.

171. We reviewed 12 finalised Comcare inspector reports on incidents of suicide, non-fatal attempts of suicide and self-harm by ADF members. These occurred during 2020 and 2021 and were notified to Comcare.¹⁹² The reports show the process of determining a 'service nexus' is complex:

- Two reports showed there was uncertainty within Defence as to whether a suicide or suspected suicide incident could be said to have a 'service nexus':
 - if the incident occurred at a private residence, and therefore outside of the workplace¹⁹³
 - before the cause of death had been determined by the Coroner.¹⁹⁴

For both of the above cases, the correct course of action was for Defence to notify Comcare.

- For three incidents, both Comcare and the Directorate of Select Incident Review within the Inspector-General of the Australian Defence Force (IGADF) conducted separate inquiries.¹⁹⁵ For two of these, IGADF investigations formed the view that there was a service nexus under the *Inspector-General of the Australian Defence Force Regulation 2016* (Cth).¹⁹⁶ However, a different determination was made by Comcare under the WHS Act.¹⁹⁷

172. The inspector reports show that determining a service nexus for psychosocial harm is not always clear cut. In one incident, Defence attributed its delay in notifying a suspected suicide, in part, to the confusion regarding the service nexus.¹⁹⁸ As such, it was police who notified Comcare in the first instance.¹⁹⁹

173. The Comcare inspector report for this incident notes:

to ensure a more robust procedure surrounding notification of serious injury and fatality incidents, Defence is revising the Air Force guide for Comcare notification to include directions regarding notification of self-harm related incidents. An extract of this was provided to the [Comcare] inspector.²⁰⁰

174. More recently, Defence has taken steps to improve this guidance at an enterprise-wide level. An update provided to the Defence Committee in June 2024 asks the Committee to note:

amendments to [the Defence Safety Manual] SafetyMan policy to reflect the Defence position that unless there is absolute clarity that there is no workplace nexus, then Comcare is to be immediately notified of all notifiable incidents, and 'if in doubt notify'.²⁰¹

175. The update to the Committee acknowledges that while Defence has previously communicated its 'if in doubt, notify' position to all Groups and Services, 'confusion still appears to exist across Defence'.²⁰² To address this:

[Defence] People Group is prioritising amendments to [the Defence Safety Manual] SafetyMan policy to support clarity and consistency. People Group will communicate policy changes extensively across the enterprise, including an update to the mandatory WHS training, which is currently under revision.²⁰³

176. Defence anticipates that the updated WHS mandatory training module will be released mid-2024.²⁰⁴ As these updates are still in development at the time of writing this report, we are unable to assess their effectiveness. We recommend that Comcare work with Defence to improve guidance and understanding of the 'if in doubt, notify' policy, including by reviewing any updates made by Defence to internal guidance and WHS training.

177. At the time of writing this report, uncertainty over how to establish the 'service nexus' for psychosocial incidents has not been eliminated by internal and external guidance on incident notification, incident notification training that Comcare developed for Defence, or the 'if in doubt, notify' policy.²⁰⁵ This is despite high completion rates of mandatory WHS training within Defence.²⁰⁶

178. This confusion over when to notify may lead to under-reporting to Comcare and impact the accuracy and understanding of trends.

179. Comcare told us that duty holders like Defence can contact the regulator to update or amend an initial notification should more information come to light.²⁰⁷ This puts the onus on Defence to self-correct in circumstances in which uncertainty over the service nexus may persist.

180. While updates to Defence's Safety Manual and mandatory WHS training to reinforce Defence's 'if in doubt, notify' policy are a step in the right direction, they do not negate the need for an assurance process.

Quality assurance for service nexus determinations

181. Where Defence does not notify Comcare of an incident, Comcare may become aware of the incident through an alternative channel, such as the WHS Helpdesk, a report by a worker or family member, police notification, media reporting or proactive inspectorate activities.²⁰⁸
182. Mr Love told us Defence has a four-person team whose full-time job is to conduct quality assurance of Defence's incident notification practices. This is intended to ensure incident reporting is consistent and notifiable incidents are reported to Comcare.²⁰⁹ Despite this, we have found that confusion and uncertainty over determining the service nexus for psychosocial incidents persists.
183. In his testimony, Comcare CEO Mr Vines agreed that:
- as a form of external assurance, Comcare could review a sample of suicide-related incidents deemed by Defence in the first instance not to have a service nexus²¹⁰
 - Comcare could use its powers under section 155 of the WHS Act to compel Defence to produce information to support such a review.²¹¹
184. When asked whether this would be a reasonable and proportionate use of Comcare's powers of information compulsion and inspection, Mr Vines agreed that it would:
- Without being able to quantify what that resource use would be ... I think it would. This is such a serious issue in the work environment that it's the most appropriate use of our resource to prevent – to get whatever information we can to prevent injury and death of working people.²¹²
185. While additional resourcing may be required, we note Comcare would only be testing a sample of relevant incidents. Any additional resourcing it required should be funded by Defence.

13.3.4 The Defence WHS Strategy Implementation Plan

186. As highlighted in Chapter 11, Governance and accountability in Defence, in August 2023 Defence produced a Draft WHS Strategy Implementation Plan. The plan outlines initiatives to improve oversight and response to psychosocial risk, governance, incident notification, psychosocial data and analysis.²¹³
187. This is a positive step forward for Defence, and we hope to see the plan implemented in line with the objectives and intent outlined.

Recommendation 56: Improve guidance and understanding of Defence's 'if in doubt, notify' policy

Comcare and Defence should work together to improve guidance and understanding of the 'if in doubt, notify' policy in relation to determinations about when to report notifiable incidents to Comcare.

Recommendation 57: Comcare to regularly review Australian Defence Force determinations of 'service nexus' for suicide attempts and suspected deaths by suicide

Comcare should improve its quality assurance of Australian Defence Force (ADF) 'service nexus' determinations made by the ADF by:

- (a) undertaking a periodic review of service nexus determinations made by the ADF for incidents of suicide, suspected suicide, attempted suicide, and non-fatal self-harm by ADF members, where the ADF has concluded that the incident did not arise out of the conduct of the ADF's business or undertaking, under section 38(1) of the *Work Health and Safety Act 2011* (Cth)
- (b) evaluating the results of these periodic reviews after three years to determine whether there is a continued need for them. The timeframe of three years will enable Comcare to test a sufficient sample size to inform its decision about whether to continue periodic reviews.

Defence should fund any additional resourcing required by Comcare to undertake these periodic reviews over the three-year period and conducts its evaluation at the end of that period.

13.4 Improving prevention and proactive intervention

- 188. An increased focus on prevention by Comcare proactively monitoring ADF psychosocial supports and interventions across the organisation will likely have a stronger impact on reducing suicide and suicidality than punitive measures alone.
- 189. Comcare's approach to regulating Defence is largely reactive and incident-based. The main trigger for Comcare engaging in monitoring, compliance and investigatory activities is Defence informing it of a notifiable incident.²¹⁴ In this section, we consider the challenges and benefits of a more proactive approach.

190. We have found that Comcare focuses on the most serious WHS Act breaches; that is, individual incidents that are likely to meet the threshold for criminal culpability. (For details, see Annexure 13.1, Criminal offences and corresponding penalties under the Work Health and Safety Act).
191. Professor Richard Johnstone, from the National Centre for Occupational Health and Safety Regulation at Australian National University, has noted that one problem with the enforcement pyramid is:
- prosecutions are only generally taken where there's a serious injury or fatality. In other words, when there's a serious injury or fatality, the regulator jumps to the top of the pyramid. When there isn't, the regulator generally plays the bottom half of the pyramid, might go up to an infringement notice or an improvement notice, or a prohibition notice.
- So in a sense the pyramid is split. It stops halfway when there's not a serious injury or fatality and we go straight to the top when there is, and I hope you'll see that one of the problems with that is that the regulator is not getting the full benefit of the pyramid because people know that the regulator won't go to the top of the pyramid unless something really bad goes wrong.²¹⁵
192. We agree. In our view, the practical effect of this responsive regulation model is there is no strong impetus for Defence to improve its approach to health and safety practices significantly at a systemic level.
193. Comcare CEO Mr Vines described prevention as its 'number one priority'.²¹⁶ Mr Vines said 'that's what our aspiration is, to be known as preventing these things happening in the first place'.²¹⁷

13.4.1 What is 'reasonably practicable' is not best practice

194. Under the WHS Act, Defence must ensure the physical and psychological health of its members when they are at work so far as is reasonably practicable.²¹⁸ The WHS Act does not define what being 'at work' encompasses, but it is not limited to being present at a physical workplace. Comcare guidance states:
- a worker is ordinarily 'at work' when the worker is performing the duties or functions for which they were engaged or caused to be engaged by the [duty holder] or is carrying out work under the [duty holder's] influence or direction.²¹⁹
195. What is 'reasonably practicable' means Defence should do what it can unless it is reasonable in the circumstances for Defence to do something less.²²⁰ Comcare can assess whether this standard has been met when it conducts an inspection. Comcare told us that when an inspector returns to assess if adequate action has been taken after a breach, their aim is to decide if a safety concern is ongoing.²²¹

196. In section 13.3.3, we reviewed 12 Comcare inspector reports on incidents of suicide, non-fatal attempts of suicide, and self-harm by ADF members. In this section, we examine how those reports showed that what is ‘reasonably practicable’ is not necessarily ‘best practice’. The WHS Act does not require Defence to adopt ‘best practice’, but this highlights the gap between what Comcare aspires to be – a regulator that supports duty holders to embrace best practice – and the standard required by law.
197. The inspector reports show that even where a Comcare inspection finds Defence has discharged its duty of care, Defence could do more to better support the wellbeing of its members.
198. For example, we note a Comcare inspector stated in the relevant report that they:
- held the reasonable belief there were further steps Defence could take to manage the risks associated with psychosocial hazards at the workplace²²²
- and
- recommended that Defence should ensure:
 - risks are eliminated or reduced
 - controls are effective, in place and used
 - relevant lessons are applied across the organisation.²²³
199. An inspector report stated:
- the control measures utilised prior to the incident complied with the WHS Act, Part 2 Health and Safety duties, section 17 through to section 19 [pertaining to Defence’s primary duty of care and its duty to eliminate or otherwise minimise risks, so far as reasonably practicable]. DoD [Department of Defence] must continue to exercise due diligence to ensure the application and ongoing effectiveness of the controls.²²⁴
200. Although the controls met the ‘reasonably practicable’ standard, they did not prevent the member from attempting suicide. Defence should look at ways to continuously improve its prevention and early intervention strategies.
201. Comcare provides guidance and advice to Defence to help it improve its WHS incident reporting and the psychosocial supports available to members. However, Defence is responsible for dismantling cultural barriers that may create resistance to or otherwise impede such reforms. These include fear of recrimination for reporting a safety incident or a lack of ADF member engagement with counselling services. Chapter 7, Culture and leadership considers the impact ADF culture has on ensuring internal processes and policies designed to support member wellbeing translate into practice.
202. Associate Secretary of Defence Mr Yannopolous told us that when measuring cultural improvement within Defence, ‘we tend to measure things to look for the absence of negative conduct’.²²⁵

203. The Defence Work Health and Safety Strategy 2023–2028 aims to ‘shift Defence’s WHS approach from a hazard-based and reactive focus to one more capable of adapting to the complex and uncertain environments which Defence faces’.²²⁶
204. Greater collaboration between Defence and Comcare would support greater proactivity. To do that effectively:
- Defence needs to collect more data relevant to psychosocial harm, including incident data and contributing factors, and provide it to Comcare.
 - Comcare requires access to meaningful trend analysis of this data by Defence. (We consider the benefits of Comcare’s access to the proposed National Veterans Data Asset in section 13.4.2).
 - Additional funding from Defence is required (as discussed in section 13.4.4).
205. In the next section, we consider how improved data collection, analysis and integration is critical in providing a clearer and more comprehensive picture of psychosocial harm in Defence.

Case study of effective partnership: Australian Federal Police

206. Like Defence, the Australian Federal Police (AFP) is a first-responder organisation that faces suicide linked to occupational trauma within its workforce.²²⁷ In his testimony, Mr Vines spoke of Comcare’s strong relationship with the AFP, which it also regulates.²²⁸
207. A key difference between Defence and the AFP is the latter is unionised. It provides a very strong voice for safety, representing the interests of workers outside the hierarchical structure.²²⁹ Conversely, Defence members are prohibited from forming or joining unions.²³⁰
208. Given the similarities between the military and policing professions as command and control organisations, there are important lessons from Comcare’s partnership with the AFP, including how collaboration could improve.
209. Mr Vines agreed there were lessons from Comcare’s partnership with the AFP that could apply to Defence. He cited the AFP’s openness with Comcare. Mr Vines said:
- We do see that there is, generally speaking, a high level of commitment ... within AFP, working with similar challenges, [to Defence]. We do feel we have quite an open access to dealing with AFP. It’s certainly not to suggest that they’re perfect but, you know, the discussions that I’ve had with the Chief Commissioner, that we’ve had with other senior people, I believe there is a high level of commitment to addressing similar sorts of issues in AFP.²³¹

Measuring effectiveness to gauge systemic improvement

- 210. Defence undertook numerous activities before and after the introduction of the new regulations dealing with psychosocial risks and hazards, to encourage a psychologically safe workplace.²³² For examples of these activities and initiatives, see Annexure 13.2, Defence efforts to manage psychosocial hazards and risks at work, and Annexure 13.3, Defence efforts to mature the psychosocial approach.
- 211. In undertaking these activities, Defence seeks to meet its obligations to identify and manage psychosocial risks.
- 212. We recognise that Defence has tools and guidance in place, and that Defence continues to develop more tools to identify and mitigate psychosocial risks. However, neither Defence nor Comcare are evaluating the effectiveness of these measures. As such, it is difficult to determine whether they are having their intended effect at a systemic level.

Implementation effectiveness is not being measured by Defence

- 213. Defence's approach to collecting and analysing data on WHS psychosocial incidents makes it difficult to evaluate whether activities and initiatives, and policy and procedural changes are having their intended effect.
- 214. Defence has acknowledged that its 'ability to measure psychosocial risk in the workplace limits Defence's assessment on whether psychosocial risk has been reduced'.²³³ To support this assessment, Defence has told us it is:

focused on maturing data use and data efforts, such as the Defence/DVA Data Sharing and Analytics Solution [DSAS] and enterprise survey improvements, which will support this assessment.²³⁴
- 215. However, Defence did not provide any further information about how the DSAS or survey improvements will be used to improve its assessment of psychosocial risk. Without this information, we remain concerned that Defence has no meaningful, concrete plan to improve how psychosocial risk can be measured and monitored.
- 216. We consider DSAS and Defence's survey program in greater detail in Chapter 29, Use of data and research by Defence and DVA. We recommend improvements to Defence's survey program, including that surveys should collect information that can be used to evaluate Defence programs and policies effectively.
- 217. Chapter 11, Governance and accountability in Defence, also discusses limitations in Defence measuring the effectiveness of implementation reforms, and mental health and wellbeing services.

Implementation effectiveness is not being measured by Comcare

218. Comcare has a reactive role in engaging with Defence. Its inspections verify Defence has complied with the WHS Act for individual incidents involving a suspected breach. As part of this, Comcare inspectors can and do make recommendations to encourage systemic improvement, but the effectiveness of these improvements is not being measured.
219. Comcare can use its powers of inspection, investigation or inquiry to assess how effectively Defence WHS policies, procedures or training comply with the WHS Act.²³⁵ However, we have not seen evidence of these powers being exercised for this purpose.
220. Mr Justin Napier, General Manager of Comcare's Regulatory Operations Group (ROG), told us Comcare has:
- a range of programs that we have put in place to [assess the practical effectiveness of Defence's policies and procedures to ensure compliance with the WHS Act] in relation to high risk hazards inside Defence where we've undertaken an inspection and required of Defence measures to address the risk ... we need to assure ourselves that any system doesn't just sit on the shelf, that it's actively being implemented in the field and applied and is effective and is subject to ongoing reviews. So we do have programs that test exactly that.²³⁶
221. However, as noted above, we reviewed 12 Comcare inspector reports on incidents of suicide and self-harm involving serving members occurring between 2020 and 2021, and two inspector reports on bullying and harassment of officer cadets in the Sydney University Regiment at Holsworthy Barracks.
222. These reports include an assessment of the supports provided by Defence for the individuals involved and the view of the Comcare inspector as to whether these supports were reasonable. However, we find that these reports do not indicate that the implementation effectiveness of Defence policies and procedures was evaluated as part of these inspections.²³⁷
223. For example, Comcare recommended that Defence take remedial actions to remedy the contraventions identified through its inspection of the Sydney University Regiment in 2021, and to apply learnings across the organisation where applicable.²³⁸
224. The follow-up inspection conducted by Comcare 3 months after the initial inspection verified that the remedial actions had been completed.²³⁹
225. Defence has advised us that:
- Army has learnt from [the Comcare inspections of the Sydney University Regiment] and other Comcare inspections and in specific cases has directed involved units to also conduct a psychosocial risk assessment and implement necessary controls to eliminate or mitigate the risks identified.
- This approach will be directed across all Army units in the near future, and will be supported by compliance and assurance activities.²⁴⁰

226. We commend this systemic approach taken by Comcare, as well as Defence's responsiveness to the regulator's recommendations. However, without any assessment of whether these measures are effective, it is difficult to know whether they are, in fact, contributing to systemic improvement.

13.4.2 Comcare is building its data capability

227. Mr Vines recognised the mutual benefit to Comcare and Defence in strengthening Defence prevention efforts to reduce demand over the long term.²⁴¹

228. We have discussed the need to make better use of data to understand root causes of and contributing factors to psychosocial harm in section 13.3.1. We noted Defence should analyse psychosocial harm trends and provide its analysis results to Comcare. Comcare agreed this would be beneficial.²⁴²

229. Mr Napier acknowledged:

We have excellent data on physical injuries because of the nature of the notification. We don't have very good data in terms of psychosocial hazards and we would encourage Defence to continue their journey through to improve that, particularly lead indicator data, and we would very much encourage them to share that with Comcare.²⁴³

230. Defence's ability to address psychosocial harm and use data to support this work is evolving. This was affirmed by Mr Vines, who told us:

like many organisations, the capacity on psychosocial is evolving. There would be very few organisations that could claim to be on top of that as an issue and Defence would be one of those [who could not make this claim].²⁴⁴

...

I don't think that there are any perfect practices around how we address this issue of latent harm associated with psychosocial hazards. We try and undertake research or partner with organisations. We would encourage Defence to join with us in a lot of that work to specifically look at these, you know, enormous risks for their workforce in that proactive way. There's no easy answer to that.²⁴⁵

231. We recognise Comcare is building its capability to use data, including to identify psychosocial risk. In his testimony, Mr Vines conceded that:

We don't use it adequately at the moment ... Data is one of our three in-house priorities to get better at capturing it and analysing it and sharing it.²⁴⁶

232. As Comcare builds this critical capability, we recommend it access the proposed National Veterans Data Asset.

Comcare access to the National Veterans' Data Asset

233. We recommend development of a National Veterans' Data Asset (Data Asset) to bring together disparate data sources on suicide, suicidality, self-harm and health (see Recommendation 107, Chapter 29, Use of data and research by Defence and DVA).
234. Relevant Australian Government and state and territory government agencies could use the Data Asset to further their understanding of suicide and suicidality among serving and ex-serving members. It would inform and enhance prevention efforts. The datasets proposed to be included in the Data Asset are detailed in Chapter 29. Such data could inform the regulatory approach to addressing psychosocial harm within Defence.
235. Comcare could use the Data Asset to access types of data to support greater understanding of workplace psychosocial risk, including:
- survey data that assesses worker attitudes and reactions to workplace culture. Mr Vines explained that insights from survey data could function as an 'early warning system' by identifying units or work groups with low positivity²⁴⁷
 - DVA compensation claims data for serving and ex-serving ADF members.
236. As the national workers' compensation authority under the *Safety, Rehabilitation and Compensation Act 1988* (Cth), Comcare has visibility of workers' compensation claims data for the duty holders it regulates. Comcare uses the rates and types of injuries identified from this to assess the inherent risk of psychosocial harms of the workforces of its duty holders, which informs its proactive and preventative work.²⁴⁸
237. However, Comcare cannot do this for the ADF because compensation claims for serving and ex-serving members are managed by DVA, not Comcare.²⁴⁹ As a result, Comcare has limited visibility of claims data for this cohort.²⁵⁰ To address this gap, we recommend Comcare access this data through the DVA PIA-V data suite, proposed to be included in the Data Asset. The data suite consolidates many DVA data sources, including basic demographic information, Military Compensation Scheme claims and payments, pensions, operational experience, treatment cards, and health service utilisations, that will be accessible to Comcare and other agencies in de-identified and aggregate form.
238. We anticipate that other data contained within the Data Asset could inform Comcare's approach to regulating psychosocial harm within Defence. However, because the Data Asset will likely take some years to establish and roll out, we see Comcare access to it as complementing:
- Comcare's existing information compulsion, inspection and investigatory powers
 - the new Defence–Comcare data analysis and sharing approach we recommend be adopted to better identify and manage psychosocial risks and hazards (Recommendation 60)

- any regulatory programs agreed between Comcare and Defence that target psychosocial harm within Defence (see section 13.4.6)
- our research findings with respect to at-risk profiles and service-related characteristics that indicate a higher risk of suicide (see Chapter 1, Understanding suicide)
- the work proposed to be done by Comcare's Psychosocial Risk Regulation Team as part of its Psychosocial Proactive Inspection Program, which we consider in the next section.

239. As an interim measure, we also strongly encourage engagement between Comcare, Defence and DVA to consider and develop potential mechanisms for Comcare to have visibility of compensation claims data, until the National Veterans Data Asset is operating.

Recommendation 58: Give Comcare access to the National Veterans' Data Asset

Comcare should have access to the National Veterans' Data Asset (Recommendation 107), to inform Comcare's regulatory approach to preventing psychosocial harm including latent harm.

13.4.3 Comcare's Psychosocial Risk Regulation Team: A positive development

240. In response to potential reforms to WHS laws recommended by the Boland Review, Comcare established its Psychosocial Risk Regulation Team to complement its existing inspectorate.²⁵¹ The team developed a Psychosocial Proactive Inspection Program to tackle the complexity associated with psychological injuries.²⁵²

241. This program focuses on early intervention and preventing harm. It was established to:

- examine the maturity of duty holders' systems in managing risks associated with psychosocial hazards. Chapter 29 considers Defence's data maturity
- identify priority areas where providing further guidance would benefit duty holders and the jurisdiction more broadly
- build on the available datasets to establish future priority areas for regulation.²⁵³

242. Mr Vines described the significance of both the team and the program to Comcare's approach to regulating psychosocial harm:

So [the Psychosocial Proactive Inspection Program is] very much a key part of our work, as is our psychosocial team in general ... both the advisory work they do, the data analysis work they do, the educative work they do. So these are still in development but very much part and parcel of the work that we're doing and align very closely with our number one priority of prevention.²⁵⁴

243. Regarding Defence, Comcare told us:

Comcare's PRRT [Psychosocial Risk Regulation Team] identified that Defence has an elevated risk relevant to psychosocial hazards due to the diverse nature of their work, the environment of heightened risk within which they operate and the likelihood of exposure to trauma.²⁵⁵

244. At the time of writing the final report, the Psychosocial Proactive Inspection Program had only been conducted on a trial basis involving three duty holders, and did not include Defence.²⁵⁶ Comcare told us that it was waiting on a formal, independent evaluation of the pilot program before deciding its future direction.²⁵⁷

245. Mr Vines told us Comcare is at the stage of getting the methodology 'right' but anticipated it would be able to commence 'this sort of program [with Defence] as soon as we [Comcare] had the staff available to do it'.²⁵⁸ He said Defence participation in such a program would require 'a willingness, an interest, a preparedness from Defence' that included funding.²⁵⁹

246. Mr Vines said, 'when we look at the cost of injuries, when we look at the cost of illness, when we look at the personal costs in the most serious cases, the cost to get this work done is negligible'.²⁶⁰ We agree.

247. Depending on the outcome of the evaluation, Defence should consider funding and participating in the Psychosocial Proactive Inspection Program. This would signal its commitment to addressing psychosocial harm at a systemic level. However, for the program itself to be effective, Mr Vines emphasised that:

[w]e'd need [Defence] to be prepared to support this right throughout the organisation. We would need them to be prepared to give us full access to the areas that we identified as a priority. We would need to agree on those areas of priority because it would be impossible to do a single program covering the whole of Defence; we would need to look at it in a programmatic sense. We would need to be assured of their cooperation the whole way through, together with a commitment to act on whatever came out of this because it would – it involves change; it involves a lot of change, if it's to have the impact that we want these programs to have.²⁶¹

13.4.4 Regulatory initiatives targeting Defence's specific needs require dedicated funding

248. Although Comcare aspires to be more proactive in the way it regulates duty holders, including Defence, its current reactive approach is reinforced by the cost-recovery model within which it operates.²⁶²

249. Comcare CEO Mr Vines explained:

Comcare is a cost-recovered regulator, which means that it charges contributions from entities in its jurisdiction for regulatory functions, including its functions under the WHS Act. In order to accommodate any expanded regulatory role in respect of the ADF, additional resources would need to be cost-recovered, or funding sought, from the Department of Defence.²⁶³

250. Mr Vines also noted Comcare enters into regulatory programs with some of its larger duty holders, targeting their specific needs:

these regulatory programs are by agreement between Comcare and the relevant [duty holder] and so the costing arrangements for those ... are part of those agreements and we will work with those organisations to identify what the priority areas are, what the scope of that relationship would need to be and then cost it accordingly.²⁶⁴

251. Without additional funding to deliver targeted programs to Defence, Comcare directs resources to regulatory activities, such as inspections, in response to incidents.

252. Comcare confirmed that it could:

- proactively use its information compulsion powers to obtain reporting and governance documents to assess individual ADF officers' accountabilities under the WHS Act²⁶⁵
- use its attendance at WHS Board meetings to monitor Defence's compliance with managing psychosocial risk more effectively.²⁶⁶

253. However, as Mr Napier explained:

in theory, we could offer more advice and guidance [to Defence] but ... in terms of cost recovery, we'd probably need to consider those issues. And would we be in a position to offer it to all of the [duty holders] in our jurisdiction? Certainly not with current resources.²⁶⁷

254. For any such programs to be effective, Mr Vines emphasised:

the overriding requirement is a full buyin from the relevant [duty holder] that [Comcare] would be engaging in particular projects on. That if we're to put resources and time into addressing specific issues in a specific [entity], we need to make sure that the work we're doing there is going to be received and acted upon and not just window dressing ... We'd need a strong commitment and be satisfied that there was a genuine desire ... to participate in ... an expanded project with us.²⁶⁸

...

a major part of support for specific joint projects needs to be that commitment to embed what comes out of these right through organisations and that's best embedded by leadership from the top and ensuring that it gets exercised at all levels in an organisation.²⁶⁹

Recommendation 59: Defence to participate in Comcare's Psychosocial Proactive Inspection Program

Defence should participate in Comcare's Psychosocial Proactive Inspection Program, once the evaluation has established it is effective.

Either:

- (a) Defence fund its participation in that program, or
- (b) a Commonwealth appropriation should be made to Comcare for the purpose of Defence's participation in the program.

13.4.5 Prosecution of the ADF for psychosocial harm rarely occurs

255. In circumstances where Comcare determines that Defence has contravened the WHS Act or WHS Regulations, it can:

- issue an improvement notice or prohibition notice
- accept a WHS undertaking if proposed by Defence
- initiate or make a referral for prosecution to the Commonwealth Director of Public Prosecutions (CDPP).²⁷⁰

256. When deciding whether to refer a brief of evidence to the CDPP, Comcare's Enforcement Committee needs to determine whether the evidence is sufficient to support a prosecution. The committee must have regard to the CDPP Prosecution Policy.²⁷¹
257. The WHS Act provides significant penalties for duty holders who commit category 1, 2 or 3 offences.²⁷² Annexure 13.1, Criminal offences and corresponding penalties under the Work Health and Safety Act, outlines the relevant offences and corresponding penalties for duty holders, including individuals.
258. Comcare told us the risks that may impact a worker's psychological health are complex and multifaceted. Therefore, non-compliance with the duty to ensure a worker's psychological health and safety may not satisfy the requisite criminal threshold of culpability for a prosecution; that is, beyond reasonable doubt.²⁷³ Of the four briefs of evidence Comcare referred to the CDPP between 2015 and 2021 for alleged Defence contraventions of the WHS Act, none related to ADF member self-harm or psychological injuries.²⁷⁴
259. More recently, however, Defence has been charged with breaches of the WHS Act in relation to psychosocial harm. In 2022, Defence was charged with breaching WHS laws for allegedly failing to manage psychosocial risks in relation to an Air Force member who died by suicide.²⁷⁵ As the first prosecution of this sort to be brought against Defence, it will be a test case for any future prosecutions.
260. In April 2024, Defence was also charged with breaches of WHS laws for allegedly exposing an Army member to a risk of death or serious injury, including the risk of self-harm or suicide, arising from stressors or mental health issues while geographically isolated from their chain of command.²⁷⁶
261. To avoid prejudicing proceedings, we will not comment further on either of these matters.
262. Comcare should continue to refer Defence and individual ADF officers for prosecution for breaches of their duty of care under the WHS Act that meet the criminal standard of culpability. This will send a powerful message that senior leaders within Defence will be held accountable. The evidentiary standard for proving such a case against an individual officer is high (appropriately so). However, this should not deter Comcare from making prosecution referrals where such referrals are warranted.

Brodie's Law: Prosecuting individual duty holders

263. There is precedent for holding individual duty holders to account for workplace bullying that has led to suicide. In 2011, Victoria passed anti-bullying legislation, known as Brodie's Law, which made serious bullying a crime punishable by up to 10 years' imprisonment.²⁷⁷ The law captures behaviour that can reasonably be expected to cause physical or mental harm to the victim, including self-harm.²⁷⁸ The definition of 'mental harm' includes psychological harm and suicidal thoughts.²⁷⁹

264. Brodie's Law was named after Ms Brodie Panlock, a victim of workplace bullying whose death by suicide precipitated the reforms. The law applies throughout Victoria's workplaces. As bullying was not a serious criminal offence in the jurisdiction at the time, each offender in the case was convicted and fined under provisions in the *Occupational Health and Safety Act 2004* (Vic).²⁸⁰ In 2017, an electrician was charged under Brodie's Law for stalking and harassing his apprentice.²⁸¹
265. Prioritising prevention strategies is of the utmost importance in eradicating workplace bullying. We acknowledge that measures such as Brodie's Law discourage individuals from engaging in bullying behaviour.

13.4.6 Comcare–Defence engagement

266. A key challenge for Comcare, as a regulator, is to strike an appropriate balance between punitive action and cooperative engagement without succumbing to 'regulatory capture'. Both Mr Napier and Mr Vines gave evidence on how stronger collaboration with Defence needs to be tempered by impartiality in Comcare's dealings with it.
267. In his testimony, Mr Napier noted that:
- I am conscious of what's known as regulatory capture ... whilst we can offer advice, guidance, assistance, we don't want to be endorsing and approving any risk assessments or risk controls necessarily as we may subsequently, if a matter comes to our attention, need to assess that from a compliance perspective and we may need to make a decision as to whether the organisation has complied. So there is a fine line there between our assistance and guidance and us endorsing or becoming a participant in the risk assessment and risk control process.²⁸²
268. Mr Vines stated:
- we are the regulator ... We have to be able to regulate and ... we have to be cautious against regulatory capture ... but certainly our priority is prevention, rather than coming in at the end of the day after the accident or illness has occurred.²⁸³
269. Comcare is clearly alive to the risks of regulatory capture, as it should be. However, this should not prevent Comcare from taking a more proactive role to better support Defence's prevention efforts. Comcare's partnership with the Australian Federal Police (AFP) shows greater collaboration can be beneficial and need not compromise Comcare's independence and impartiality. See section 13.4.1.
270. One area of opportunity for more meaningful engagement between Comcare and Defence is at the three separate forums that focus on WHS matters. However, as we next discuss, these forums are primarily used to provide updates (for example, on work programs), rather than addressing emerging or actual WHS risks on a strategic level.

Comcare–Defence Liaison Forum

271. The Comcare–Defence Liaison Forum is a bi-annual meeting attended by the Defence secretariat, Comcare’s Regulatory Operations Group (ROG) General Manager Mr Napier and all available ROG regional directors.²⁸⁴ The Comcare CEO does not usually attend.²⁸⁵
272. The forum’s terms of reference are to:
- enable information exchange, discussion, consultation and advocacy about key WHS matters, issues, resolution and determinations
 - forge a relationship between Defence and Comcare to identify and address emerging or actual WHS risks on a strategic level.²⁸⁶
273. We found the forum is only partially achieving these objectives. The evidence before us indicated that, in practice, the forum is ‘predominantly an information exchange’ where Defence and Comcare provide updates rather than address emerging or actual WHS risk.²⁸⁷ The meetings result in few or no action items.²⁸⁸

Defence Work Health and Safety Board

274. Comcare’s ROG General Manager has a standing invitation to attend the Work Health and Safety Board (WHS Board) meetings, which are held three times a year.²⁸⁹ Defence and Comcare have disparate views over the latter’s contribution to these meetings.
275. Ms Celia Perkins, Deputy Secretary of Security and Estate in Defence and the former Chair of the WHS Board, characterised Comcare’s role in the meetings as ‘advisory’ and going ‘well beyond administrative engagement’.²⁹⁰ According to Ms Perkins, Comcare ‘hold[s] a mirror up to the senior leaders in the board on their experience of ... Defence incidents and investigations’.²⁹¹
276. Comcare CEO Mr Vines told us its General Manager attends ‘certain parts of the meeting’ to provide updates to the Board.²⁹² Comcare General Manager Mr Napier gave evidence that he only attends the meetings to provide ‘high-level ... oversight of the risk management [and] risk identification activities that Defence is undertaking and among those risks are psychosocial risks’.²⁹³
277. Our review of the meeting minutes supports Comcare’s evidence that it has a limited, largely administrative role in the form of providing updates.²⁹⁴
278. We accept that frank and fearless conversations are necessary and more likely to occur without the regulator in the room. However, if Comcare is to ‘hold a mirror up to senior leaders in the board’, we consider there are opportunities for more meaningful and active contributions at WHS Board meetings.²⁹⁵

Suicide and Self-harm Working Group

279. In early 2022, Comcare's ROG established the Suicide and Self-harm Working Group (also referred to as the Defence and Comcare Fatalities meeting group).²⁹⁶ According to Ms Weston:

The original purpose of the group was: to work together on agreed reporting requirements, improving the quality of information requests [by Comcare] and [Defence's] response [to these requests], and address any information gaps to support Comcare's Inspectorate to achieve an improved and more consistent response to self-harm matters.²⁹⁷

280. On 16 March 2023, the draft terms of reference for the working group expanded its purpose to include Defence suicide and self-harm, as well as outcomes of the Defence and Veteran Suicide Royal Commission.²⁹⁸ The draft terms of reference define the group's purpose as:

(1) [Enabling] information exchange, discussion, consultation and advocacy to promote a holistic understanding of:

factors that contribute to self-harm by Defence members, and

proposed improvements to WHS systems and mental health services across Defence to address these.

(2) In the context of assurance, monitoring the response by Defence to the Royal Commission into Defence and Veteran Suicide.²⁹⁹

281. Members from Comcare's ROG and representatives from Defence's WHS Branch are permanent members of the group.³⁰⁰ Meetings occur quarterly and are co-chaired by the General Manager of Comcare's ROG and the Assistant Secretary of the Defence WHS Branch.³⁰¹ Additional participants may be invited to provide subject matter knowledge to support discussions, but they have no voting rights in final decisions.³⁰²

282. Comcare's CEO stated there was a clear correlation between the issues considered by the working group and a range of measures introduced by Defence, including the establishment of particular functions and teams. However, he could not directly attribute these activities to the working group.³⁰³

283. Further, issues raised in the working group relating to Comcare access to Defence sites and Defence information for the purpose of Comcare inspections are ongoing.³⁰⁴ Mr Napier confirmed these access issues have created barriers to Comcare investigating psychosocial incidents 'in the short term'; however, 'in the medium to longer term ... we will find a way to gather the information'.³⁰⁵ We are concerned that engagement at the working group level has not resolved these site and information access issues, causing delays to critical information being received by Comcare.

284. If Defence was more receptive to Comcare's participation in engagement forums, Comcare would not need to rely on sanctions and powers of compulsion.³⁰⁶ Comcare's participation is critical to supporting systemic change within Defence because there are limits to what Comcare can achieve using its powers of enforcement.

Recommendation 60: Improve strategies for harm prevention and early intervention by sharing quality data with Comcare

To improve Comcare's ability to inform prevention and early intervention strategies for suicide and latent harm arising from Australian Defence Force service, Defence should:

- (a) share with Comcare on a quarterly basis through the Suicide and Self-Harm Working Group meeting:
 - (i) data on psychosocial harm (including data relating to notifiable and non-notifiable incidents)
 - (ii) Defence's analysis of this data to identify systemic issues related to psychosocial harm
- (b) share with Comcare through the Defence-Liaison Form meeting what actions it has taken to document and implement controls to address systemic hazards, risks and issues relating to psychosocial harm.

13.5 Conclusion

285. WHS systems are critical in identifying psychosocial risks and hazards, and developing strategies to mitigate or reduce the likelihood of these risks or hazards eventuating.
286. We have identified opportunities to improve Defence's WHS systems to better identify and respond to psychosocial risks for its members and employees.
287. Quality data and analysis is foundational in understanding trends and hot spots, and intervening early to minimise harm.
288. Risk categorisation needs to reflect the evidence to ensure that risks receive the appropriate level of attention. Controls to mitigate or reduce risk need to be continuously reviewed for effectiveness and addressed where they are found to be ineffective. This has not occurred in Defence, as evidenced by its lack of detailed and transparent attention to the findings of the Mental Stress Review.

289. We note that Comcare is working to improve data collection and analysis, and understand psychosocial risk. We recommend more engagement between Comcare and Defence on prevention strategies. We also recommend Defence improves its data sharing with Comcare to support this objective.

Annexure 13.1 Criminal offences and penalties under the Work Health and Safety Act

Box A1 Criminal offences and corresponding penalties under the *Work Health and Safety Act 2011* (Cth)

The Commonwealth, which includes the Australian Defence Force (ADF), is a duty holder under the *Work Health and Safety Act 2011* (Cth) (WHS Act). As such, it has health and safety duties imposed by the Act.³⁰⁷ This includes the primary duty of care to ensure the physical and psychological health and safety of ADF members.³⁰⁸

‘Officers, workers and other persons’ also have health and safety duties under the WHS Act.³⁰⁹ A person who makes, or participates in making, decisions that affect the whole, or a substantial part, of a business or undertaking of the Commonwealth is taken to be an officer of the Commonwealth for the purposes of the WHS Act.³¹⁰

A breach of a health and safety duty is a criminal (not civil) offence. As such, the prosecution must meet the criminal standard of proof; that is, the case must be proven ‘beyond reasonable doubt’ (as opposed to ‘on the balance of probabilities’).

There are three categories of criminal offences of differing severity for breaches of these duties. These categories are set out in the table below. The maximum penalties differ depending on the category of offence and whether the offender is an individual (such as a worker), an officer or a body corporate.³¹¹ The penalties that apply to the Commonwealth are the same as those that apply to body corporates.³¹²

In addition to making penalty orders, a court can make various other orders, including adverse publicity orders.³¹³

To date, Comcare has not brought prosecutions against an individual ADF officer for breaches of the WHS Act.³¹⁴ However, it has brought prosecutions against Defence as a duty holder.

Table A1 Criminal offences and corresponding penalties under the *Work Health and Safety Act 2011* (Cth)

Section of WHS Act	Details of relevant offence	Penalty for body corporate (including the Commonwealth)	Penalty for an individual who commits an offence as a person conducting a business or undertaking, or as an officer of such person (<i>that is, a person in control of a business</i>)	Penalty for individuals in other circumstances
Section 31	Category 1 Offence – Negligence or reckless conduct A duty holder, without reasonable excuse, engages in conduct with gross negligence or is reckless as to the risk to an individual of death or serious injury or illness. ³¹⁵	\$15,000,000 ³¹⁶	\$3,000,000 ³¹⁷ or 15 years imprisonment or both ³¹⁸	\$1,500,000 ³¹⁹
Section 32	Category 2 Offence – Failure to comply with health and safety duty A duty holder fails to comply with a health and safety duty that exposes a person to risk of death or serious injury or illness. ³²⁰ Note: recklessness or negligence is not required. Reasonable excuse is also not a factor to be considered.	\$2,090,000 ³²¹	\$418,000 ³²²	\$209,000 ³²³
Section 33	Category 3 Offence – Failure to comply with health and safety duty A duty holder fails to comply with a health and safety duty. ³²⁴ Note: This can be any failure.	\$700,000 ³²⁵	\$140,000 ³²⁶	\$70,000 ³²⁷

* The prosecution bears the burden of proving that the conduct was engaged in without reasonable excuse for a Category 1 Offence: section 31(2).

** The test of negligence for the Commonwealth is that set out in section 5.5 of the *Criminal Code Act 1995* (Cth): section 245BA(1).

Note: Two or more contraventions of a health and safety duty provision that arise out of the same factual circumstances may be charged as a single offence or as separate offences.³²⁸ If multiple contraventions are charged as a single offence, only a single penalty applies.³²⁹

Annexure 13.2 Defence efforts to manage psychosocial hazards and risks at work

Defence has advised us that it has ‘introduced guidance, training, tools and other initiatives to support Defence workplaces to identify and mitigate psychosocial risks’.³³⁰ As outlined in the tables below, some of these initiatives were intended to implement the *Model Code of Practice for Managing Psychosocial Hazards at Work* (Model Code of Practice)³³¹

Table A2 Defence efforts to implement the *Model Code of Practice for Managing Psychosocial Hazards at Work*

Effort	Description (as provided by Defence) ³³²
Defence Psychosocial Risk Management Policy	<p>In June 2022, the Defence Psychosocial Risk Management Policy was endorsed by First Assistant Secretary People Services and was promulgated via [the Defence Safety Manual] SafetyMan.</p> <p>SafetyMan is the primary source of WHS policy for Defence and is to be used in conjunction with the WHS Act and WHS Regulations 2011. All Groups and Services must comply with SafetyMan policy and guidance.</p> <p>The Policy addresses core elements and encompasses Defence's primary duty under the WHS Act 2011, section 19. In doing so, the Policy supports the enterprise to manage psychosocial risks and hazards including addressing factors in the design and management of work that increase the risk of work-related stress, which can lead to psychological or physical harm. The Policy was developed mindful of the anticipated changes in the WHS laws and in line with the then draft Model Code of Practice for managing psychosocial hazards at work.</p>
Psychosocial Risk Control Stocktake	<p>In September 2022 Defence undertook the Stocktake which provided a snapshot in time of the efforts underway across managing psychosocial hazards at work.</p> <p>This stocktake informed the development of the Psychosocial Risk Areas of Effort intended to strengthen the enterprise's approach to psychosocial risk management in Defence. On 7 October 2022, the Defence Work Health Safety Board endorsed five areas of effort:</p> <ol style="list-style-type: none"> 1. Guidance and Tools; 2. Education, Training and Programs; 3. Surveillance; 4. Governance; and 5. Assurance

Effort	Description (as provided by Defence) ³³²
Defence Psychosocial Risk Portal	<p>[Defence People Group] DPG launched the Defence Psychosocial Risk Portal (the Portal) on 28 March 2023 as a one-stop-shop to assist leaders and individuals in managing these workplace psychosocial hazards and based on four step process outlined in Model Code of Practice for managing psychosocial hazards at work.</p> <p>The Portal provides fact sheets for controlling hazards, there is information about the legislation changes (including a webinar), there is a psychosocial hazard identification tool and a risk register and various links to supporting resources. The Portal is accessible to all Defence employees on the Defence intranet.</p> <p>In May 2023, DPG reviewed the Defence Psychosocial Risk Management Policy to ensure continued alignment to the Model Code of Practice for managing psychosocial hazards at work and amendments to the Work Health Safety Model Regulations on 1 April 2023.</p>

Source: Exhibit F-03.016, Hearing Block 12, Department of Defence, Response to Notice to Give, NTG-DEF-162, DEF.9999.0113.0056, Table 12.2 at 0078–0079.

Table A3 Defence efforts to implement Safe Work Australia guidelines entitled 'Work-related psychological health and safety: A systematic approach to meeting your duties'

Effort	Description (as provided by Defence) ³³³
Defence WHS Strategy 2017-2022	<p>The Defence WHS Strategy 2017-2022 outlined Defence's WHS vision and strategic focus areas for that period.</p> <p>This included a focus on healthy and safe workplaces through the effective identification and management of physical and psychological risks, as well as assurance and continuous safety analysis and audit to inform and improve hazard and risk management.</p>
Defence Mental Health and Wellbeing Strategy 2018-2023	<p>The Defence Mental Health and Wellbeing Strategy 2018-2023 outlines Defence's six Strategic Objectives designed to address the mental health and wellbeing needs of ADF and APS workers.</p> <p>These objectives include providing a thriving culture and healthy workplace, understanding the emerging mental health and wellbeing needs of workers, and continually improving programs and services. In doing so, provides some alignment to the Safe Work Australia guidelines.</p>
Defence APS Psychological Health Awareness: Recognising the Early Warning Signs of Workplace Stressors Defence Psychosocial Resource Guide and Hazard/Risk Checklist Quick Reference Guide What to do if an Employee is Showing Signs of Workplace Stress DI(G) 35-3 Management and reporting of unacceptable behaviour	<p>Collectively, these documents identified or advised the following:</p> <ul style="list-style-type: none"> • Early warning signs of workplace stress include irritability, indecisiveness, absenteeism, reduced performance, and increased mistakes. • Psychosocial hazards were defined as being related to the aspects of the design, organisation and management of work which can contribute to psychological injury. • Psychological injury was defined as a form of injury generally associated with work-related stress. • Work-related stress was defined as a term often used to describe the responses that may develop when employees are subjected to demands and expectations within their work environment that cannot be reasonably maintained or are not consistent with their needs, abilities, skills and coping strategies. • Managers and Supervisors are responsible (so far as is reasonably practicable) for ensuring physical and psychological health of employees. • Once a psychosocial hazard is identified, strategies need to be developed at the workplace. This should involve all employees in the affected area to find a solution.

Effort	Description (as provided by Defence) ³³³
Fact Sheet Information for Managers, Supervisors and Commanders in Managing their Ill or Injured APS Employees	<ul style="list-style-type: none"> If it is identified that it is not possible to eliminate the risk, then strategies are to be developed to mitigate or deal with the impact. Further assessments should be carried out every six months to review the progress of the strategies put in place. More specifically, the Interim Defence Instruction advised the following: <ul style="list-style-type: none"> All Defence personnel are to report and manage incidents through either the Defence Australian Public Service Line of Management or Australian Defence Force Chain of Command. Incidents may involve the wellbeing of Defence personnel, infringement of legislation or regulatory requirements, implications for safety and security, potential damage to organisational reputation or brand, and/or damage to equipment and facilities. 'Defence personnel who have reasonable suspicion that an incident has occurred ... must, as soon as practicable ... report the incident to their manager or commander.' Managers and Commanders must record details of the reporting and management of incidents in the authorised case management system using a Defence incident record. Incidents are defined as 'any non-routine event or occurrence that may have an effect on Defence, in particular, capability, operations, personnel ...' Record means to put all required information about an incident into an approved form for use within an authorised case management system. Authorised case management system is defined as 'any information technology enabled case management system authorised through this interim instruction and/or the Incident Reporting and Management Manual'. The Incident Reporting and Management Manual provides guidance to all Defence personnel on what constitutes an incident and how those incidents are to be reported. The recording systems listed in the Incident Reporting and Management Manual for reporting incidents include Sentinel for safety incidents and Comtrack for incidents relating to unacceptable behaviour.
EAP Critical Incidents Management Services Guide	
Policy Guidance – Medical Rehabilitation (Return to Work) Policy Statement for Defence Australian Public Service Employees	
Directorate of APS Rehabilitation Frequently Asked Questions to Guide Ill and Injured APS Employees	
Interim Defence Instruction Administration 45-2 Incident Reporting and Management (Interim Defence Instruction)	
Incident Reporting and Management Manual	
Defence Incident Record Form AE530 (Blank) <i>All of the above [efforts] are enduring initiatives that now apply on an ongoing basis.</i>	

Source: Exhibit F-03.016, Hearing Block 12, Department of Defence, Response to Notice to Give, NTG-DEF-162, DEF.9999.0113.0056, Table 12.2 at 0078–0079.

Annexure 13.3 Defence efforts to mature the psychosocial approach

A chronology of efforts by the Defence People Group (DPG) and its Deputy Secretary to mature Defence's psychosocial approach between 2019 and 2023 was included in the statement of Justine Grieg PSM, Deputy Secretary, DPG.³³⁴ This chronology is reproduced here.

Table A4 Chronology: Efforts by the Defence People Group to mature Defence's psychosocial approach 2019–2023

Date	Activity	Description	Outcome
2019	Defence WHS Monthly Scorecard	The scorecard was introduced to provide senior leaders with a regular and timely snapshot of current WHS information across Defence	Since 2019, the Monthly Scorecard reported aggregated numbers on fatalities and psychosocial incidents by each Group/Service to the Senior Leadership Round Table meeting. In October 2022 the Scorecard evolved into a Quarterly Dashboard with 5 year trends. Interactive functionality was developed in February 2023 to enable Group and Service representatives to drill through to incident details to support their own analysis. The scorecard includes unacceptable behaviour data provided by our ComTrack system. Group and Service representatives can also view incident details within Sentinel (WHS Management Information System) or STARS (Safety Trend Analysis and Reporting Solution). Psychosocial incidents are considered sensitive and a Sentinel or STARS user must provide a business justification/need to know in order to access this information.
Sep 2020	Psychosocial Enhancement to the Defence WHS Management Information System, Sentinel	'Did the Event relate to suicide, attempted suicide, self-harm or mental illness?' was added to the initial assessment questions in Sentinel.	This question enables improved identification and analysis of suicide, attempted suicide, self-harm and suicidality.
Nov 2020	WHS Risks Report	This report provided analysis on information between 1 July 2014 to 30 June 2020 as a follow up to the Enterprise Work Health Safety Risks Analysis Paper submitted to the EBC in January 2020.	Mental Stress was identified as an area of risk for Defence with mental stress incidents on an increasing trend over the reporting period.

Date	Activity	Description	Outcome
2020	The Defence Safety Behaviour Review	The Defence Safety Behaviour Review commenced in 2020 to establish a baseline of safety behaviour and culture across the Defence enterprise. This work culminated in a report released in 2022. A number of recommendations set out in the report relate to initiatives that address psychosocial risk.	The Safety Behaviour Review was finalised and endorsed through the EBC and Defence Committee. Nine areas of effort were identified, and further broken down into 11 key activities that form the basis of the implementation plan. Seven of these activities are already in progress and four more will commence in 2023.
Mar 2022	Compassionate Foundations training course	In response to recommendations outlined by the National Suicide Prevention Adviser to the Prime Minister, Defence and the APSC collaborated to develop a bespoke whole-of-service approach to building suicide prevention capability through the Compassionate Foundations eLearning course.	Compassionate Foundations is a skills-led learning approach for the APS and ADF that is compassion-based, sustainable and focused on building positive human-to-human interactions that promote understanding and connection. The course is designed to support Defence personnel (including contractors) at all levels to build the skills required to respond early, before a person's experience leads them to become distressed and/or suicidal.
Jun 2022	Defence Psychosocial Risk Management Policy	Defence Psychosocial Risk Management Policy was endorsed by First Assistant Secretary People Services and was promulgated via the Defence Safety Manual (SafetyMan). SafetyMan is the primary source of WHS policy for Defence and is to be used in conjunction with the Work Health and Safety Act 2011 and Work Health and Safety Regulations 2011. All Groups and Services must comply with SafetyMan policy and guidance. This policy applies to all Defence workers, including ADF members and cadets, APS employees, contractors and other persons.	The Policy addresses core elements and encompasses Defences primary duty under the WHS Act 2011, Section 19. In doing so, the Policy supports the enterprise to manage psychosocial risks and hazards including addressing factors in the design and management of work that increase the risk of work-related stress, which can lead to psychological or physical harm. The Policy was developed mindful of the anticipated changes in the WHS laws.

Date	Activity	Description	Outcome
Sep 2022	WHS Focus Area Report	Work Health and Focus Area Report was submitted to the November 2022 Defence WHS Board. The report provided analysis on WHS incidents between July 2017 and June 2022 as a follow up to the Enterprise WHS Risks Report in 2020.	<p>Analysis identified significant increases in the number of involved people in the following hazard sources over the five year analysis period:</p> <ul style="list-style-type: none"> • Vehicle incidents; • Psychosocial; and • Electrical. <p>This work focuses WHS efforts across the Defence enterprise.</p>
13 Sep 2022	Defence Psychosocial Risk Control Stocktake	Developed a short term approach to mature Defence's Approach to Psychosocial Risk. A workshop was held with Group and Service representatives to discuss the Psychosocial Risk Control Stocktake, which is a snapshot in time of the efforts underway across Defence to manage psychosocial risk against the Model Code of Practice – How to Manage Work Health and Safety Risks.	<p>This work identified a number of areas where Defence has numerous existing controls such as efforts which address bullying, harassment (including sexual misconduct), workplace conflict, and the physical environment. In contrast, various opportunities were identified areas of improvement, where Defence could introduce or improve existing controls, these include role clarity, job demand, job control, and organisational justice.</p>
7 Oct 2022	Defence Work Health Safety Board Outcomes	<p>An extraordinary Defence Work Health Safety Board meeting was conducted seek endorsement on actions to improve Defence approach to psychosocial risk and wellbeing initiatives.</p> <p>Included was a dedicated draft psychosocial deep dive interrogating the data and findings of the Work Health and Focus Area Report.</p>	<p>The Board:</p> <ul style="list-style-type: none"> • Agreed to elevate psychosocial incidents as a WHS focus area for Defence; and • Endorsed the Psychosocial Risk Areas of Effort as the enterprise's immediate way forward to strengthen psychosocial risk management in Defence: <ul style="list-style-type: none"> ◦ Guidance and Tools ◦ Education, Training and Programs ◦ Surveillance ◦ Governance ◦ Assurance

Date	Activity	Description	Outcome
21 Nov 2022	New Mental Health and Wellbeing Branch	DGMHW Appointed	The appointment of the DGMHW signified the initiation of an implementation team to establish the new branch.
2023 – under development	Defence Mental Health and Wellbeing Strategy	Defence and DVA have committed to the development of a joint Mental Health and Wellbeing Strategy. Previously each department had separate but complementary strategies.	The joint strategy approach will result in a whole-of-life focus on the mental health and wellbeing of ADF members, veterans and their families. The strategy will cover in-service, transition and post-service considerations.

Source: Exhibit 64-02.001, Hearing Block 9, Justine Greig, Witness Statement, DEF.9999.0087.0001, Table 19.1 at 0053–0056.

Endnotes

- 1 Work Health and Safety Act 2011 (Cth) s 19(1).
- 2 Exhibit 28-01.001, Hearing Block 12, Susan Weston, Witness Statement, SWE.0000.0001.0001 at 0004.
- 3 Exhibit L-01.080, Department of Defence, Response to Notice to Give, NTG-DEF-199, DEF.9999.0132.0068 at 0093–0095 [Table 2.11].
- 4 Work Health and Safety Regulations 2011 (Cth) regs 34, 35, 55A, 55B.
- 5 Australian Institute of Health and Wellbeing, Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 1997 to 2021, 2022, p 11 (Exhibit K-01.123, DVS.2222.0001.3284).
- 6 Work Health and Safety Act 2011 (Cth) s 3; Exhibit 28-01.001, Hearing Block 4, Susan Weston, Witness Statement, SWE.0000.0001.0001 at 0004.
- 7 Work Health and Safety Act 2011 (Cth) s 35.
- 8 Work Health and Safety Act 2011 (Cth) s 3(1).
- 9 Work Health and Safety Act 2011 (Cth) s 152(b).
- 10 Transcript, Gregory Vines, Hearing Block 12, 22 March 2024 at p 98-9996 [45].
- 11 Exhibit 28-01.001, Hearing Block 4, Susan Weston, Witness Statement, SWE.0000.0001.0001 at 0013 [45].
- 12 Exhibit 28-01.001, Hearing Block 4, Susan Weston, Witness Statement, SWE.0000.0001.0001 at 0006 [23]; Comcare, Compliance and Enforcement Policy – A policy for Comcare’s compliance and enforcement activities, p 8 (Exhibit 28-01.009, Hearing Block 4, COM.0001.0002.0367).
- 13 See: Comcare, Compliance and Enforcement Policy – A policy for Comcare’s compliance and enforcement activities, p 4 (Exhibit 28-01.009, Hearing Block 4, COM.0001.0002.0367); Transcript, Susan Weston, Hearing Block 4, 11 April 2022, p 28-2554 [11–26]; M Ivec and others, ‘Applications of Responsive Regulatory Theory in Australia and Overseas: Update’, occasional paper, 23, March 2015, p 7 (Exhibit SS-01.009, DVS.6666.0001.5141); See also John Braithwaite, ‘Responsive Regulation’, webpage, www.johnbraithwaite.com/responsive-regulation, viewed 5 February 2024 (Exhibit P-01.042, DVS.0000.0001.9424).
- 14 Transcript, Susan Weston, Hearing Block 4, 11 April 2022, p 28-2554 [11–18].
- 15 Exhibit 28-01.001, Hearing Block 4, Susan Weston, Witness Statement, SWE.0000.0001.0001 at 0033 [126].
- 16 Exhibit 28-01.001, Hearing Block 4, Susan Weston, Witness Statement, SWE.0000.0001.0001 at 0013 [45(b)].
- 17 Transcript, Susan Weston, Hearing Block 4, 11 April 2022, p 28-2554 [24–41].
- 18 Work Health and Safety Act 2011 (Cth) s 152(c); Comcare, Compliance and Enforcement Policy – A policy for Comcare’s compliance and enforcement activities, p 8 (Exhibit 28-01.009, Hearing Block 4, COM.0001.0002.0367).
- 19 Comcare, Compliance and Enforcement Policy – A policy for Comcare’s compliance and enforcement activities, p 8 (Exhibit 28-01.009, Hearing Block 4, COM.0001.0002.0367).
- 20 Comcare, Compliance and Enforcement Policy – A policy for Comcare’s compliance and enforcement activities, pp 7–8 (Exhibit 28-01.009, Hearing Block 4, COM.0001.0002.0367).
- 21 Comcare, Compliance and Enforcement Policy – A for Comcare’s compliance and enforcement activities, p 7 (Exhibit 28-01.009, Hearing Block 4, COM.0001.0002.0367).
- 22 Transcript, Gregory Vines, Hearing Block 12, 22 March 2024, p 98-10002 at [10–29].
- 23 Transcript, Gregory Vines, Hearing Block 12, 22 March 2024, p 98-10002 at [26–29].
- 24 Work Health and Safety Act 2011 (Cth) ss 4, 19.
- 25 Department of Defence, ‘About Defence – Work Health and Safety’, webpage, www.defence.gov.au/about/complaints-incident-reporting/work-health-safety, viewed March 2024 (Exhibit NN-01.003, DVS.0000.0002.0794).
- 26 Work Health and Safety Act 2011 (Cth) s 35–38.
- 27 Work Health and Safety Act 2011 s 12D(2).
- 28 Work Health and Safety Act 2011 (application to Defence activities and Defence members) Declaration 2012 (Cth); Work Health and Safety Act 2011 (Cth).
- 29 Work Health and Safety Regulation 2017 (Cth) reg 35.
- 30 Work Health and Safety Regulation 2017 (Cth) reg 35.
- 31 Work Health and Safety Regulations 2011 (Cth) reg 55C.

- 32 Work Health and Safety Regulations 2011 (Cth) reg 34.
- 33 Work Health and Safety Regulations 2011 (Cth) regs 35(a), (b).
- 34 Work Health and Safety Regulations 2011 (Cth) reg 55A; Safe Work Australia, Managing Psychosocial Hazards at Work: Code of Practice, July 2022, p 5 (Exhibit SS-01.016, DEF.1148.0001.0603).
- 35 Work Health and Safety Regulations 2011 (Cth) reg 55B.
- 36 Work Health and Safety Regulations 2011 (Cth) reg 55C.
- 37 Work Health and Safety Act 2011 (Cth) s 18(a); Comcare, 'Regulatory guide – Primary duty of care', webpage, 6 February 2024, www.comcare.gov.au/scheme-legislation/whs-act/regulatory-guides/primary-duty-of-care, viewed 11 June 2024 (Exhibit P-01.059, DVS.4444.0001.0288).
- 38 Work Health and Safety Act 2011 (Cth) s 18(b); Comcare, 'Regulatory guide – Primary duty of care', webpage, 6 February 2024, www.comcare.gov.au/scheme-legislation/whs-act/regulatory-guides/primary-duty-of-care, viewed 11 June 2024 (Exhibit P-01.059, DVS.4444.0001.0288).
- 39 Work Health and Safety Act 2011 (Cth) s 18(c)(i).
- 40 Work Health and Safety Act 2011 (Cth) s 18(c)(ii).
- 41 See M Boland, Review of the Model Work Health and Safety Laws Final Report, December 2018, p 35 [Recommendation 2] (Exhibit 28-01.036, Hearing Block 4, COM.0001.0002.0793).
- 42 Department of Defence, Defence Annual Report 2020-2021, September 2022, p 91 (Exhibit 16-01.031, Hearing Block 3, DVS.0000.0001.3686).
- 43 Exhibit 86-03.025, Hearing Block 12, Defence Work Health and Safety Board – Terms of Reference (March 2023), DEF.1274.0002.0334 at 0335.
- 44 Exhibit 86-03.025, Hearing Block 12, Defence Work Health and Safety Board – Terms of Reference (March 2023), DEF.1274.0002.0334 at 0335.
- 45 Exhibit L-01.080, Department of Defence, Response to Notice to Give, NTG-DEF-199, DEF.9999.0132.0068 at 0129.
- 46 Exhibit 86-03.025, Hearing Block 12, Defence Work Health and Safety Board – Terms of Reference (March 2023), DEF.1274.0002.0334 at 0335.
- 47 Exhibit 86-03.025, Hearing Block 12, Defence Work Health and Safety Board – Terms of Reference (March 2023), DEF.1274.0002.0334 at 0335.
- 48 Exhibit 86-03.025, Hearing Block 12, Defence Work Health and Safety Board – Terms of Reference (March 2023), DEF.1274.0002.0334 at 0335.
- 49 Exhibit 99-01.001, Hearing Block 12, 2023 Defence Risk Management Framework, DEF.1310.0002.0010 at 0014.
- 50 Exhibit 99-01.001, Hearing Block 12, 2023 Defence Risk Management Framework, DEF.1310.0002.0010 at 0019.
- 51 Exhibit 99-01.046, Hearing Block 12, 2023 Enterprise Risk Report, DEF.1376.0001.1075_R, Attachment F – Defence Risk Appetite and Tolerance Statement, p 9.
- 52 Work Health and Safety Regulations 2011 (Cth) pt 3.1.
- 53 Exhibit L-01.120, Defence People Committee – 23 March 2023 – DPC2023/012 – Biannual Enterprise Workforce Report, DEF.1233.0001.0103.
- 54 Exhibit L-01.120, Defence People Committee – 23 March 2023 – DPC2023/012 – Biannual Enterprise Workforce Report, DEF.1233.0001.0103 at 0103 at 0103 [1].
- 55 Exhibit L-01.120, Defence People Committee – 23 March 2023 – DPC2023/012 – Biannual Enterprise Workforce Report, DEF.1233.0001.0103.
- 56 Exhibit L-01.120, Defence People Committee – 23 March 2023 – DPC2023/012 – Biannual Enterprise Workforce Report, DEF.1233.0001.0103 at 0122 Annex 1 to Attachment C.
- 57 Exhibit P-01.017, Defence Enterprise Risk Report – November 2020, DEF.1151.0005.0386 at 0386.
- 58 Exhibit 99-01.001, Hearing Block 12, Defence Risk Management Framework, 2023, DEF.1310.0002.0010 at 0019.
- 59 Transcript, Matthew Yannopoulos, Hearing Block 12, 25 March 2024, p 99-10085 [26–28].
- 60 Exhibit P-01.017, Defence Enterprise Risk Report – November 2020, DEF.1151.0005.0386 at 0387.
- 61 Exhibit 99-01.046, Hearing Block 12, Enterprise Business Committee, 23 November 2023 – Enterprise Risk Report, DEF.1376.0001.1075_R.
- 62 Exhibit 99-01.046, Hearing Block 12, Enterprise Business Committee, 23 November 2023 – Enterprise Risk Report, DEF.1376.0001.1075_R at p 2.

63 Exhibit 99-01.046, Hearing Block 12, Enterprise Business Committee, 23 November 2023 –
Enterprise Risk Report, DEF.1376.0001.1075_R at p. 4.

64 Exhibit F-03.056, Bi-Annual Enterprise Work Health and Safety Focus Areas Report 2015-
2020, Graph 5 – Body Stressing by Calendar Year, DEF.1096.0001.1226 at 1234.

65 Exhibit 99-01.046, Hearing Block 12, Enterprise Business Committee, 23 November 2023 –
Enterprise Risk Report, DEF.1376.0001.1075_R at p 9.

66 Transcript, John Love, Hearing Block 12, Tuesday 19 March 2024, p 95-9572 [34–40].

67 Exhibit BB-01.004, Draft Defence WHS Strategy Implementation Plan, August 2023,
DEF.1269.0003.0827, pp 0835 and 0854.

68 Transcript, John Love, Hearing Block 12, Tuesday 19 March 2024, p 95-9585 [35–40].

69 Transcript, John Love, Hearing Block 12, Tuesday 19 March 2024, p 95-9585 [42–46].

70 Department of Defence, Enterprise Control Effectiveness Assessment, dated August 2023 and
signed by Justine Greig 29 September 2023, p 2 (Exhibit ZZ-02.001, DEF.1288.0002.0357).

71 Work Health and Safety Regulations 2011 (Cth) regs 55A–55D.

72 Exhibit ZZ-02.006, Department of Defence, Defence Committee 03 Jun 2024 Psychosocial
Deep Dive, DEF.1419.0003.0139 at 0143 [23].

73 Transcript, John Love, Hearing Block 12, Tuesday 19 March 2024, p 95-9585 [15–17].

74 Exhibit F-03.056, Bi-Annual Enterprise Work Health and Safety Focus Areas Report 2015–
2020, DEF.1096.0001.1226 at 1228.

75 Exhibit F-03.049, Work Health and Safety Focus Area: Mental Stress, 1 January 2019 to 30
June 2021, DEF.1221.0001.0869 at 0871.

76 Exhibit F-03.049, Work Health and Safety Focus Area: Mental Stress, 1 January 2019 to 30
June 2021, DEF.1221.0001.0869 at 0871.

77 Exhibit F-03.049, Work Health and Safety Focus Area: Mental Stress, 1 January 2019 to 30
June 2021, DEF.1221.0001.0869 at 0872, 0873.

78 Exhibit F-03.049, Work Health and Safety Focus Area: Mental Stress, 1 January 2019 to 30
June 2021, DEF.1221.0001.0869 at 0875.

79 Exhibit F-03.049, Work Health and Safety Focus Area: Mental Stress, 1 January 2019 to 30
June 2021, DEF.1221.0001.0869.

80 Exhibit F-03.005, Work Health and Safety Focus Area: Mental Stress, Project Completion
Report, DEF.1221.0001.0934 at 0939.

81 Exhibit F-03.005, Work Health and Safety Focus Area: Mental Stress, Project Completion
Report, DEF.1221.0001.0934 at 0939.

82 Exhibit F-03.005, Work Health and Safety Focus Area: Mental Stress, Project Completion
Report, DEF.1221.0001.0934 at 0939.

83 Exhibit F-03.005, Work Health and Safety Focus Area: Mental Stress, Project Completion
Report, DEF.1221.0001.0934 at 0939.

84 Transcript, John Love, 1 Hearing Block 12, 9 March 2024, p 95-9571 [34–39].

85 Transcript, John Love, Hearing Block 12, 9 March 2024, p 95-9572 [1–2].

86 Exhibit F-03.005, Work Health and Safety Focus Area: Mental Stress, Project Completion
Report, DEF.1221.0001.0934 at 0940.

87 Exhibit F-03.005, Work Health and Safety Focus Area: Mental Stress, Project Completion
Report, DEF.1221.0001.0934 at 0935.

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Royal Commission
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